1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form (PM). Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08982

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis —
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - Anne Arundel General.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ofarlue - Md
d. STREET ADDRESS: 8704 Tioga Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James. Middle: . Last: Aberg.

4. DATE OF DEATH: Month: 7 Day: 18 Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-11-65

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Alexandria, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert L. Aberg

14. MOTHER'S MAIDEN NAME: Anne H Heltzel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (MOTHER): Anne H. Aberg — Address: 8704 Tioga Rd. Glen Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Injury Head.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): auto accident - Truck Trailer

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 7/18/1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): APG (County): (State): MD

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. Linhardt M.D.
EXAMINER'S NAME (Type): F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED: 7-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-22-67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.

23d. LOCATION (City or Town): Colmar Manor, Md. (County): (State):

24. FUNERAL DIRECTOR: J. Wm. Lee & Sons

ADDRESS: Wash. DC 4th & Mass. Ave. N.E.

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08983

1. PLACE OF DEATH
   a. COUNTY: H.A.Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel - General.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pa — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Media — 75-3
   d. STREET ADDRESS: N. Providence Road.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: J. — Last: Ammon

4. DATE OF DEATH: Month: 7 — Day: 3 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-29-64

9. AGE (In years last birthday): 3 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Sharon Hill, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert D. Ammon

14. MOTHER'S MAIDEN NAME: Catherine Ammon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Richard Ammon (Uncle) — Address: Cape St. Clair Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Crushing Injury Skull — INTERVAL BETWEEN ONSET AND DEATH: 25 MINS
   DUE TO
   (b):
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 7-3 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): — (County): Paca — (State): MD

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D.

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 7-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: July 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Mem. Cem.

23d. LOCATION (City or Town) (County) (State): Broomall Pa.

24. FUNERAL DIRECTOR: Robert J. Beall Jr. — ADDRESS: Beall Funeral Home 1212 West St. Anna.

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15ME (5)
6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08984

1. PLACE OF DEATH
   a. COUNTY: A.A. Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Pa
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Media — 75-3
   d. STREET ADDRESS: W. Providence Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: D — Last: Ammon

4. DATE OF DEATH: Month: 7 — Day: 3 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-12-32

9. AGE (In years last birthday): 35 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tel. Co.

10b. KIND OF BUSINESS OR INDUSTRY: Cable Splicer

11. BIRTHPLACE (State or foreign country): Phila. Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Arthur Ammon

14. MOTHER'S MAIDEN NAME: Adelaide Ammon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Richard Ammon (Brother) Address: Cape St. Clair Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Basilar Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
   816.1
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b)
   DUE TO
   (c)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 7/3 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): AACo MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): E. Lindhardt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 7-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Mem. Cem.

23d. LOCATION (City or Town) (County) (State): Broomall Pa.

24. FUNERAL DIRECTOR: Beall Funeral Home ADDRESS: 4272 West St. Anna.

25a. RECD BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 Film 391
8-11-67 ame

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08986 08985

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1348 Chester Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle — Last ATKINSON

4. DATE OF DEATH: Month July — Day 6, — Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-20-35

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labr

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washingtn DC

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roosevelt Atkinson

14. MOTHER'S MAIDEN NAME: Martha Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Martha Smith — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laennec's cirrhosis with marked fatty
DUE TO (b): metamorphosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
581.1
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: July 7, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-15-67

23c. NAME OF CEMETERY OR CREMATORY: Mt Lebanon Cem

23d. LOCATION (City or Town) (County) (State): A.A. Co Md

24. FUNERAL DIRECTOR: Thos Wilson — ADDRESS: 1001 Brantly Rd

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingling

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08987 08986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 9 Taney Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: G. — Last: ATWELL
4. DATE OF DEATH: Month: July — Day: 2 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-16-1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (County & State, or foreign country): Annapolis Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: ANGELO J. GERACI
14. MOTHER'S MAIDEN NAME: MARY COLBURN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: TILDEN O. ATWELL — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs
DUE TO (b): Art. C. V. Disease & Hypertension — ?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H43X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/1, 1967, to 7/2, 1967 that (I) (we) last saw the deceased alive on 7/2, 1967, and that death occurred at 12:50 A.M. from causes and on the date stated above.

22a. SIGNATURE: Maurice F. Klawans M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/3/67
22c. PHYSICIAN'S NAME (Type): M.F. KLAWANS, M.D.
22d. ADDRESS: 31 SOUTHGATE AVE

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7-4-67
23c. NAME OF CEMETERY OR CREMATORY: St. Anne's
23d. LOCATION (City or Town) (County) (State): Annapolis A.A. MD.
24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: JUL 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item #2c & d Film #

08988 — 08987

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 21223
d. STREET ADDRESS: 207 Amity St. /Crownsville/Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Ida — Middle: — Last: Barnes

4. DATE OF DEATH: Month: 7 — Day: 31 — Year: 1967

5 SEX: F

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: -/-/81

9 AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY: unemployed

11 BIRTHPLACE (County & State, or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edmond Gittins

14 MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Address: Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4200
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
3
Chronic Brain Syndrome

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/19, 1962, to 7/31/, 1967, that (I) (we) last saw the deceased alive on 7/31/ 1967, and that death occurred at 6:30 M, from causes and on the date stated above.

22a SIGNATURE: L. Benedict

M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 7/31/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d ADDRESS: Crownsville State Hospital, Maryland

1

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8-4-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

23d. LOCATION (City or Town) (County) (State): Balto, Md.

24. FUNERAL DIRECTOR: Morton & Dyett F. H.

ADDRESS: 1701 Laurens St.

25a. REC'D BY REGISTRAR DATE: AUG 3 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08989

CERTIFICATE OF DEATH

08989

1 PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town): ST. MARYARETTS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BAY MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 504 STATE St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GERTRUDE — Middle: MARY — Last: BARRY

4. DATE OF DEATH: Month: 7 — Day: 25 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-9-1877

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): FAIRMOUNT, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LEONARD RUARK

14. MOTHER'S MAIDEN NAME: ELIZABETH McGRATH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: WALTER BARRY — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): BRONCHO PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE.

9. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour / a.m. / p.m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from DEC, 19 58, to 25 July, 1967, that (I) (we) last saw the deceased alive on 16 APR. 1967, and that death occurred at 8 A. M., from causes and on the date stated above.

22a. SIGNATURE: Edward L. Barry — M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 7/25/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: 2 RARKLIN St. ANNAPOLIS, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7-28-67

23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR: John M. Taylor — ADDRESS: Ann Arundel, Md.

25a. REC'D BY REGISTRAR DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08990 08989

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 924 Wells Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leonard — Middle: Joseph — Last: BARRY

4. DATE OF DEATH: Month: July — Day: 11 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 13, 1896

9 AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CIVIL SERVICE

10b KIND OF BUSINESS OR INDUSTRY: Rct

11 BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOSEPH BARRY

14. MOTHER'S MAIDEN NAME: GERTRUDE RUARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI

16 SOCIAL SECURITY NO. 214056639A

17. INFORMANT: Address: FELICIA H. BARRY #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Gastrointestinal Bleeding — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): (?) peptic ulcer — 17 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic CVD

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (~~his/her~~) attended the deceased from 7-10-59 19___, to July 11, 1967, that (I) (~~he~~) last saw the deceased alive on July 11 1967, and that death occurred at 5:20 PM, from causes and on the date stated above.

22a. SIGNATURE: Frank M. Shipley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-13-67

22c. PHYSICIAN'S NAME (Type): F M. SHIPLEY

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 7-14-67

23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24 FUNERAL DIRECTOR: John M. Loyola & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08891 08930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Edgemere~~ - Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Convalescent Ctr

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Edgemere~~ - Glen Burnie
d. STREET ADDRESS: 17 Rosedale Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Katherine — Middle: — Last: BARTEL
4. DATE OF DEATH: Month: 7 — Day: 25 — Year: 1967
5 SEX: F
6. COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 12-18-87
9 AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b KIND OF BUSINESS OR INDUSTRY: Telephone Co.
11 BIRTHPLACE (County & State, or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: Henry Streckfus
14. MOTHER'S MAIDEN NAME: Barbara Fehr

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16 SOCIAL SECURITY NO: 217-20-6259
17 INFORMANT: Richard N. Bartel — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I — DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): ASHD
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHF

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour: a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/5/67, 19__, to 7/25/67 19__, that (I) (we) last saw the deceased alive on 7/23/67 19__, and that death occurred at 6A M, from causes and on the date stated above

22a SIGNATURE: J. B. Ramirez M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED:
22c PHYSICIAN'S NAME (Type): J. B. RAMIREZ
22d ADDRESS: 3527 ANNAPOLIS RD Balto 27 1677 NORTHBOURNE RD Balto 12

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/28/67
23c NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
23d LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: R. P. Ware — ADDRESS: Singleton Funeral Home Glen Burnie, Md.
25a REC'D BY REG'STRAR DATE: JUL 27 1967
25b REG'STRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08992 08991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1602 Sunshine street Glen Burnie
d. STREET ADDRESS: Crownsville, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Liston — Middle: E. — Last: Batson

4. DATE OF DEATH: Month: 7/ — Day: 19 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 5/5/06

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Seaman

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Batson

14. MOTHER'S MAIDEN NAME: Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service): Yes USCG

16. SOCIAL SECURITY NO: 156-03-5558

17. INFORMANT — Address: G Hospital Records, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive Heart Failure
DUE TO
(c): Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Right leg(Operated-open reduction)Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/ 3, 1967 to 7/19, 1967, that (I) (we) last saw the deceased alive on 7/19, 1967, and that death occurred at 2:00 P.M., from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☐ — MED DIRECTOR ☒ — STAFF PHYS ☐

22b. DATE SIGNED: 7/19/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 22, 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: [signature] — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland

25a. FILED BY (REGISTRAR): JUL 21 1967 — DATE

25b. (SIGNATURE OF REGISTRAR): [signature]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08993

08992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ANNAPOLIS
d. STREET ADDRESS: RIVA ROAD R.F.D #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: THEODORE — Middle: F. — Last: BAUSUM

4. DATE OF DEATH: Month: JULY — Day: 28 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-15-1920

9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): EXCAVATING

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): A. A. Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN E. BAUSUM

14. MOTHER'S MAIDEN NAME: MARY FARRELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service: YES WWII-KOREA

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: DOROTHY S. BAUSUM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Caught between Body & Frame of Dump Truck

20c. TIME OF INJURY Month, Day, Year, Hour a.m. (p.m.): 7/25 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): RIVA — (County): MD. — (State):

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county):

22. DATE SIGNED: 7/28/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-31-67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City or Town): Annapolis — (County): — (State): MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Foy Funeral Home Annapolis, Md.

25a. RECD BY REGISTRAR — DATE: AUG 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08994 — 33993

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Rural
c. LENGTH OF STAY IN 1b: 29 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Rural
d. STREET ADDRESS: 411 Old Stage Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Daniel — Middle: A. — Last: Beckman

4. DATE OF DEATH: Month: 7 — Day: 4 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-10-01

9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Purch. Agent

10b. KIND OF BUSINESS OR INDUSTRY: Md. Cup Co.

11. BIRTHPLACE (County & State, or foreign country): ~~Washington~~ Wash. D.C.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: William Beckman

14. MOTHER'S MAIDEN NAME: Katherine Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1919-1923

16. SOCIAL SECURITY NO.: 218-12-4352

17. INFORMANT (Address): Mrs. Martha Beckman (wife) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial insufficiency
DUE TO (b): Coronary Art. disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: H Summers — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-5-67

22c. PHYSICIAN'S NAME (Type): H. G. Summers MD

22d. ADDRESS: 1161 Patapsco Ave Balto

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR: Eugene B. Hemming

ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08995 — 08994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shou a be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 **PLACE OF DEATH**
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edlesville
c. LENGTH OF STAY IN 1b: 50 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Edlesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First: Sarah — Middle: Grace — Last: BENNING

4 **DATE OF DEATH**: Month: July — Day: 27 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/21/92
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Ashland, Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Andrew Wagner
14. MOTHER'S MAIDEN NAME: Ida May Libby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO: —
17. INFORMANT: Harry Benning — Address: Edlesville Md.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of Stomach & metastases
DUE TO (b): to lung and thoracic spine
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 years
151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 19 62, to June 27, 19 67, that (I) (we) last saw the deceased alive on June 29 1967, and that death occurred at 3 P.M. from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith, M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/28/67
22c. PHYSICIAN'S NAME (Type): Willard F. Smith, MD
22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/30/67
23c. NAME OF CEMETERY OR CREMATORY: Zucker
23d. LOCATION (City or Town) (County) (State): Edlesville MD Md

24. FUNERAL DIRECTOR: Bernard Hardesty — ADDRESS: Edlesville Md

25a. REC'D BY REGISTRAR DATE: AUG 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Flm 7/31/67 ph

28896

CERTIFICATE OF DEATH

3295

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Maryland 21[illegible]
d. STREET ADDRESS: 1058 Arnold Ave. Crownsville, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Duane — Middle: B. — Last: Best

4. DATE OF DEATH: Month: 7 — Day: 31 — Year: 19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In year last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
M	N		7/12/38	29 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		North Caroline	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Louis Best	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	219-30-8447	Hospital Records, Crownsville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY-
493 X
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Alcoholism
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that ~~(I)~~ (this hospital) attended the deceased from 6/26, 1967, to 7/31/, 1967, that ~~(I)~~ (we) last saw the deceased alive on 7/31/ 1967, and that death occurred at 12:00 M, from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 7/31/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D

22d. ADDRESS: Crownsville, State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	8/5/67	Mt Calvary Cemetry	A A County Md

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Adolphus Halstead 1206 W North Ave.	AUG 2 1967	[signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08997 — 08996

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Augustus — Last: BIRCKHEAD

4. DATE OF DEATH: Month: July — Day: 18 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 6, 1892

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State or foreign country): Paris — Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Albert E. Birckhead

14. MOTHER'S MAIDEN NAME: Helen Proutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 212-14-8729

17. INFORMANT — Address: Mason Birckhead - Gambrills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs.
DUE TO (b): Art. C V.R. Disease — 4 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile Dementia C.V-A

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ ~~coroner~~) attended the deceased from 7/18, 1967, to July 18, 1967, that (I) (XX) last saw the deceased alive on July 18, 1967, and that death occurred at 9:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Maurice R Klawans M.D. — ATTENDING PHYS. XX — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Maurice Klawans, MD

22d. ADDRESS: 31 Southgate Ave., Annapolis, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/21/67

23c. NAME OF CEMETERY OR CREMATORY: Middletown Cem.

23d. LOCATION (City or Town) (County) (State): Lusby Calvert Md

24. FUNERAL DIRECTOR — ADDRESS: Hopping Funeral Home Annapolis Md.

25a. RECD BY REGISTRAR DATE: JUL 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08998

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03997

1 PLACE OF DEATH
a COUNTY: AA Co. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c LENGTH OF STAY In 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MD. — b COUNTY: ANNE ARUNDEL
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ANNAPOLIS
d STREET ADDRESS: HARNESS CREEK
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James. Middle: J. Last: Blackwell

4 DATE OF DEATH: Month: 7 Day: 14 Year: 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 2-22-1907

9 AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service

10b KIND OF BUSINESS OR INDUSTRY: Ret.

11 BIRTHPLACE (State or foreign country): Hartsville S. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: James A. Blackwell

14 MOTHER'S MAIDEN NAME: Tiny Chase

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II

16 SOCIAL SECURITY NO

17 INFORMANT: Elizabeth V. Blackwell — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
850X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Boating Accident - Chesapeake Bay

20c TIME OF INJURY Month Day Year Hour a.m. p.m.: 7/13 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay

20f (City or town): (County): AA Co. (State): MD

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E. L. Johnson Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town & county):

22. DATE SIGNED: 7-14-67.

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-18-67

23c NAME OF CEMETERY OR CREMATORY: Hillcrest

23d LOCATION (City or Town) (County) (State): Annapolis A.A. MD.

24 FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis, Md.

25a RECD BY REGISTRAR DATE: JUL 18 1967

25b REGISTRAR'S SIGNATURE: Charles Grogg

VR A15ME (5) 6M 1/67

1 5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08999 08993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 403 Irene Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 403 Irene Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leona — Middle: — Last: Boggs
4. DATE OF DEATH: Month: July — Day: 22 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 30, 1875
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Franklin Furnace, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Andrew T. Bryan
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Lorraine Evans — Address: 403 Irene Drive Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Advanced age
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/6, 1957 to 7/22, 1967, that (I) (we) last saw the deceased alive on 7/11 1967, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph Taler, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): JOSEPH TALER
22d. ADDRESS: 95 Hopkins Rd. Glen Burnie Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 7/24/67
23c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery
23d. LOCATION (City, town or county) (State): Ashland, Kentucky

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave. Baltimore, Md.
25a. REC'D BY REGISTRAR DATE: JUL 25 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jyoge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09000 08999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ploga Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
d. STREET ADDRESS: 3316 W. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DAVid Middle: Last: Booze

4. DATE OF DEATH: Month: July Day: 14 Year: 1967

5. SEX: Male

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-8-1886

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper Hanger

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S. America

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 214-10-0050

17. INFORMANT: Joseph Sims Address: P.O. Box 23 Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b): Palmonary congestion — 1 Day
DUE TO (c): Residual pneumonia — several weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-21, 1962 to 7-14, 1967 that (I) (we) last saw the deceased alive on 7-14-1967, and that death occurred at 10:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Richard H. Hunt

22d. ADDRESS: 100 Cherry Lane, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-19-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Nelson Funeral Home

ADDRESS: 1348 Calhoun Street

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 5-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09001 — 09000

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- Hanover
d. STREET ADDRESS: Hillcrest Rd., Timberridge
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: M. — Last: Bosien

4. DATE OF DEATH: Month: 7 — Day: 12 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-31-99

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State, or foreign country): Dorsey Anne Arundel Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ambrosius

14. MOTHER'S MAIDEN NAME: Margaret Reimsnyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): XXXXXX no ////////

16. SOCIAL SECURITY NO.: 213 48 9818

17. INFORMANT: Elsworth Bosien (son) — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 2000 — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (b): Carcinomatosis general
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Reticulo-cell Sarcoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 66, 1966, to 7/12, 1967, that (I) (we) last saw the deceased alive on Jan 11 1967, and that death occurred at 5:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph Taler, M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/12/67

22c. PHYSICIAN'S NAME (Type): JOSEPH TALER

22d. ADDRESS: 45 ARVA HART Rd. Glen Burnie, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 15/67

23c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery

23d. LOCATION (City or Town) (County) (State): Howard Co., Maryland

24. FUNERAL DIRECTOR: L. O. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUL 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09002

CERTIFICATE OF DEATH

09001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rt. 5 Box 207

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: Rt. 5, Box 207
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: C. — Last: Botzler

4. DATE OF DEATH: Month: 7 — Day: 13 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-17-67 1894

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): DANVILLE. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HARVEY M. SEIDEL

14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215 03 5138

17. INFORMANT: MRS. GEORGE K. KUEHNE #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): A.C.H.D.
DUE TO (c): Senility

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955, 19__, to 1967, 19__, that (I) (we) last saw the deceased alive on 7-7-67, 19__, and that death occurred at 8 A M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-13-67

22c. PHYSICIAN'S NAME (Type): Robert R. Hahn, M. D.

22d. ADDRESS: P.O. Box 73, Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-16-67

23c. NAME OF CEMETERY OR CREMATORY: ASBURY

23d. LOCATION (City, town or county) (State): ARNOLD MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09003

CERTIFICATE OF DEATH

09002

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Montgomery County — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Montgomery County
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clara — Middle: — Last: Bowen

4. DATE OF DEATH: Month: 7 — Day: 10 — Year: 67

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1898

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (County & State, or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, Crownsville Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Congestive Heart Failure
DUE TO
(c): Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/13, 1913, to 7/10/, 1967, that (I) (we) last saw the deceased alive on 7/10 19 67 and that death occurred at 12:15 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 7/10/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 7/21/67

23c. NAME OF CEMETERY OR CREMATORY: [illegible] Mt.

23d. LOCATION (City or Town) (County) (State): Balto. Md.

24. FUNERAL DIRECTOR: William Reese — ADDRESS: [illegible] Md.

25a. REC'D BY REGISTRAR DATE: JUL 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09004 — 09003

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~FAROLE~~
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RIVA ROAD

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAROLE
d. STREET ADDRESS: RIVA ROAD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: JOSEPH — Middle: DELL — Last: BOWEN
4 DATE OF DEATH: Month: 7 — Day: 29 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 1-29-1881
9 AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING
10b KIND OF BUSINESS OR INDUSTRY: FARM
11 BIRTHPLACE (County & State, or foreign country): CALVERT CO. MD.
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: REVERDY BOWEN
14 MOTHER'S MAIDEN NAME: ANNIE M. RAWLINGS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: ELIZA H. BOWEN — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): INANITION — INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS
DUE TO
(b): CARCINOMA OF PROSTATE — SEVERAL YERS
DUE TO
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
177X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PNUEMONIA RIGHT LOWER LOBE, ARTERIOSCLEROSIS

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to 29 Jul, 1967 that (I) (we) last saw the deceased alive on 29 Jul 1967, and that death occurred at 8:30 P.M. from causes and on the date stated above.

22a SIGNATURE: Charles W. Kinzer MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 31 Jul 67
22c PHYSICIAN'S NAME (Type): CHARLES W. KINZER, MD.
22d ADDRESS: 16 MURRAY AVE ANNAPOLIS, MD 21401

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 8-1-67
23c NAME OF CEMETERY OR CREMATORY: ASBURY
23d LOCATION (City or Town) (County) (State): BARSTOW MD.

24 FUNERAL DIRECTOR: John M. Layton & Sons — ADDRESS: Annapolis, Md.
25a RECD BY REGISTRAR DATE: AUG 2 1967
25b REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09005 — 09004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Rural
c. LENGTH OF STAY IN 1b: ////////
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Rural
d. STREET ADDRESS: 120 Baltimore Ave. S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amelia — Middle: M. — Last: Brosh

4. DATE OF DEATH: Month: 7 — Day: 4 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-06
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Holzner
14. MOTHER'S MAIDEN NAME: Catherine E. Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Mrs. Helen M. Baisley (daughter) Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe Cerebral Vascular Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Severed Pain accidents or type
DUE TO
(c): CIRRHOSIS OF LIVER - ALCOHOLIC
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Dr Carlos E Arrabal M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 7-4-67.
22c. PHYSICIAN'S NAME (Type): CARLOS E ARRABAL
22d. ADDRESS: 2705 MOUNTAIN RD - 21122.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Eugene B Fleming — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09006

CERTIFICATE OF DEATH

09005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: AnneArundel
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL, Davidsonville
   d. STREET ADDRESS: Fran-Mar Farm
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Lucy Virginia Middle BROWN Last
4. DATE OF DEATH: Month July Day 22 Year 1967
5. SEX: female
6. COLOR OR RACE: Cauc.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: ~~MAY 3~~ March 6, 1928
9. AGE (In years last birthday): 39 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Afton, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOSHUA FRANKLIN KINZER
14. MOTHER'S MAIDEN NAME: LUTIE MARGARET (KINZER) WILGUS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: (Husband) John M. Brown, same address — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asthma, acute, allergen unknown — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
   Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
   DUE TO (b): Asthma, perennial, multiple allergens — 15 years
   DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 30, 19 67, to July 22, 19 67, that (I) (we) last saw the deceased alive on March 30 1967, and that death occurred at 2:08 A M, from the causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer, M. D.
M.O. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: July 22, 1967
22c. PHYSICIAN'S NAME (Type): Charles W. Kinzer, M. D.
22d. ADDRESS: 16 Murray Avenue, Annapolis, Md. 21401

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: July 25, 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF CEM.
23d. LOCATION (City, town or county) (State): ANNAPOLIS Md.

24. FUNERAL DIRECTOR: Robert J. Beall Jr. — ADDRESS: BEALL FUNERAL HOME, ANNAPOLIS 112 WEST ST.
25a. REC'D BY REGISTRAR DATE: JUL 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09007 Item 9 Fil. 6/30/67 rk 09006

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a COUNTY: A.A. MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY:
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton	c. LENGTH OF STAY IN 1b: 6 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
	d. STREET ADDRESS: Broadwater Rd. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: Charles	Middle: A.	Last: Buissett	4. DATE OF DEATH	Month: July	Day: 5	Year: 1967	
5 SEX: M	6. COLOR OR RACE: W	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 12/10/09	9 AGE (In years last birthday): 57 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment operator	10b KIND OF BUSINESS OR INDUSTRY: AA Co	11 BIRTHPLACE (County & State or foreign country): Hart, Michigan	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Buissett		14 MOTHER'S MAIDEN NAME: Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO: 223 03 3337	17 INFORMANT: Essie D Buissett	Address: Churchton Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Jan 61, 19 61, to July 5, 19 67, that (I) (we) last saw the deceased alive on June 1 19 67, and that death occurred at 7 P M, from causes and on the date stated above.

22a SIGNATURE: Willard F Smith	M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED: 7/7/67	
22c PHYSICIAN'S NAME (Type): Willard F. Smith, MD	22d. ADDRESS: Shady Side, Md.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 7-7-67	23c NAME OF CEMETERY OR CREMATORY: Eden Haven Cemetery	23d LOCATION (City or Town) (County) (State): Eden Burnie AA Md	
24 FUNERAL DIRECTOR: Bernard Hardesty	ADDRESS: Galesville Md	25a RECEIVED BY REGISTRAR DATE: JUL 13 1967	25b REGISTRAR'S SIGNATURE: [illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09008 — 9007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Halethorpe
d STREET ADDRESS: 1936 Brady Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Burns
4. DATE OF DEATH: Month: July — Day: 17 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/8/1891
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor
10b KIND OF BUSINESS OR INDUSTRY: Warehouse
11. BIRTHPLACE (County & State, or foreign country): Georgia
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I
16 SOCIAL SECURITY NO.: 219 02 3434
17. INFORMANT: Lennox Ingram — Address: 2415 Zion Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Arteriosclerosis
DUE TO (c): Carcinoma of Bladder

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/26, 1965, to July, 1976, that (I) (we) last saw the deceased alive on 7/10 1967, and that death occurred at 11:30 A.M., from causes and on the date stated above

22a SIGNATURE: Ray M. Smith — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 17 July 1967
22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M. D.
22d ADDRESS: Hahn Professional Building, Severna Pk.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/21/67
23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Andrew J. [illegible] 1922 Lafayette Ave. Bal.
25a RECD BY REGISTRAR DATE: JUL 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingst

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09009

CERTIFICATE OF DEATH

09008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 56 yrs. +
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Reese Road

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Reese Road (Rt. #2)
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First EVA — Middle M. — Last BUSSEY

4. DATE OF DEATH: Month JULY — Day 5 — Year 1967

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8 DATE OF BIRTH: Dec. 22, 1894

9 AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Lerch

14. MOTHER'S MAIDEN NAME: Helen Barjak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17 INFORMANT: Mrs. Minnie Escavage (daughter) — Address 7001 Athol Ave. Balto. 27

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.
DUE TO (b): Arteriosclerosis, Generalized — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to July 5, 1967 that (I) (we) last saw the deceased alive on July 1, 1967, and that death occurred at 9:15 M, from causes and on the date stated above.

22a. SIGNATURE: Edward G. Skerritt — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c PHYSICIAN'S NAME (Type): Edward G. Skerritt, M.D.

22d. ADDRESS: Gambrills, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 8, 1967

23c NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24 FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Singleton Funeral Home, Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: JUL 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09009

09010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: AA. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): DOA-North Baltimore-Hosp. 5469-Kenton-Rd

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MD — b. COUNTY: AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Janice — Middle: D — Last: Cain

4 DATE OF DEATH: Month: 7 — Day: 29 — Year: 19 67

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 10-14-48

9 AGE (In years last birthday): 18 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Md

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Melvin Cain

14 MOTHER'S MAIDEN NAME: June Birrane

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): auto struck fixed object

20c TIME OF INJURY Hour: a.m. p.m. Month: 7 Day: 29 Year: 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Highway

20f (City or town): AA Co (County): (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D

EXAMINER'S NAME (Type): E. Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county):

22. DATE SIGNED: 7-29-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8/1/67

23c NAME OF CEMETERY OR CREMATORY: Balto Natl Cem

23d LOCATION (City or Town): Balto Co (County): (State): Md

24 FUNERAL DIRECTOR: McCully F H 237 Patapsco Ave 21225 — ADDRESS

25a REC'D BY REGISTRAR DATE: JUL 31 1967

25b REGISTRAR'S SIGNATURE: Juliana Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3) 2
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

99011 — **CERTIFICATE OF DEATH** — 99013

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 90 Charles St.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 90 Charles St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Nannie — Middle: C. — Last: Callahan

4 DATE OF DEATH: Month: 7 — Day: 10 — Year: 67

5 SEX: Female

6 COLOR OR RACE: Col.

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: 8/19/93

9 AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Galax, Va.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Wesley Choate

14 MOTHER'S MAIDEN NAME: Ellen Hamilton

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 214 44 1879

17. INFORMANT — Address: Thomas L. Callahan 90 Charles St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of Pancreas
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 5/11/67, 19___, to ____, 19___, that (I) (we) last saw the deceased alive on ____ 19___, and that death occurred at ___ M, from causes and on the date stated above.

22a SIGNATURE: Stephen B. Hiltabidle M.D — M.D ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED:

22c PHYSICIAN'S NAME (Type): Stephen B. Hiltabidle, M.D.

22d ADDRESS: 121 Cathedral St. Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-15-1967

23c NAME OF CEMETERY OR CREMATORY: Oak Grove

23d LOCATION (City or Town) (County) (State): Bluewell Md. Va.

24 FUNERAL DIRECTOR — **ADDRESS**: William Reese # Annapolis Md.

25a RECORDED BY REGISTRAR — DATE: JUL 12 1967

25b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09011

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH
a. COUNTY: Balto. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A — Anne Arundel Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: [redacted]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville —
d. STREET ADDRESS: 330 Stratford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Edward — Middle: W — Last: Chaffman
4 DATE OF DEATH: Month: 7 — Day: 9 — Year: 1967

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
M	W		4-23-08	59 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Commercial Representative
10b KIND OF BUSINESS OR INDUSTRY: Western Union Tel. Co
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: Walter E Chaffman
14 MOTHER'S MAIDEN NAME: Annie Poulsen
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 215 03 7478
17 INFORMANT: Mary E. Chaffman — Address: 330 Stratford Rd

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: Long
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
11344

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhart M.D.
EXAMINER'S NAME (Type): E. Linhart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 7-9-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7-12-67
23c NAME OF CEMETERY OR CREMATORY: Woodlawn Cem
23d LOCATION (City or Town) (County) (State): Woodlawn Baltimore Co Md

24 FUNERAL DIRECTOR: Burgee Funeral Home — ADDRESS: 3631 Falls Rd Balto
25a RECD BY REGISTRAR: DATE: JUL 11 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1 '67

1-47

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09013 09012

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 699 Saint Martins Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle — Last: Chick
4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/14/19
9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Carling Glass Co.
11. BIRTHPLACE (County & State, or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Micheal Chick
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Air Force 1942-194 5
16. SOCIAL SECURITY NO.: 218-07-4205
17. INFORMANT — Address: Hospital Records Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute and organizing massive myocardial
DUE TO: infarction on the heart.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Thrombosis of arteriosclerotic coronary
DUE TO: vessels.
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive cardiovascular disease; chronic Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 12/5/ 1966 to 7/24/ 1967, that (I) (we) last saw the deceased alive on 7/24/ 1967, and that death occurred at 7:20 a M, from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.
22d. ADDRESS: Crownsville, Maryland 21032

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland
24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce 4001 Ritchie Hgwy, Balto, Md
25a. RECD BY REGISTRAR DATE: JUL 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09014 09013

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physic an and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 441 Poplar Road

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville (P.O.)
d. STREET ADDRESS: 441 Poplar Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STEPHEN — Middle — Last CIRRI
4. DATE OF DEATH: Month July — Day 31 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18 Feb. 1910
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintance Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: U.M. V.
11. BIRTHPLACE (County & State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Joseph Cirri
14. MOTHER'S MAIDEN NAME: Marie Corsello
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 212-03-4622
17. INFORMANT: Mrs/ Laura Cirri - Wife(same as # 2
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cancer of bone — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (b): Carcinomatosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1761

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 6, 1966, to July 31, 1967, that (I) (we) last saw the deceased alive on July 31 1967, and that death occurred at 1:5 PM, from causes and on the date stated above.

22a. SIGNATURE: Robert Dalsing — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/31/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3 Aug 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home/ Glen Burnie, Maryland
ADDRESS
25a. REC'D BY REGISTRAR: AUG 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09015 (09014)

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit Then please remove carbon papers. Pages 1 and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNAPOLIS NURSING HOME

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 117 LAFAYETTE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lee — Middle: F. — Last: Clemens
4 DATE OF DEATH: Month: JULY — Day: 29 — Year: 1967
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3-11-1894
9 AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAIL CARRIER RET.
10b KIND OF BUSINESS OR INDUSTRY: U.S. GOVM'T
11 BIRTHPLACE (County & State or foreign country): Milton, Pa.
12 CITIZEN OF WHAT COUNTRY?: U.S.
13 FATHER'S NAME: ANDREW CLEMENS
14 MOTHER'S MAIDEN NAME: BETTIE NORICONK
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW I
16 SOCIAL SECURITY NO:
17 INFORMANT: CATHERINE B. CLEMENS — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cancer of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1963, 19__, to 7/29, 1967 that (I) (we) last saw the deceased alive on 7/10 1967, and that death occurred at 12:50 A M, from causes and on the date stated above.

22a SIGNATURE: Maurice F Klawans M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/29/67
22c PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS
22d. ADDRESS: 31 SOUTHGATE AVE

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 8-1-67
23c NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
23d LOCATION (City or Town) (County) (State): Balto MD.
24 FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis Md.
25a RECD BY REGISTRAR DATE: AUG 2 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 Hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09016 — 09015

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   c. LENGTH OF STAY IN 1b: 09 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   d. STREET ADDRESS: 1 SOUTHGATE AVENUE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
SCHAMYL	(NMN)	COCHRAN	JULY	1	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	CAU		25 MARCH 1886	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COMMANDER	USN RETIRED	HOUSTON, TEXAS	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JEROME BOWLING COCHRAN	ANNE WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES 1904-1946	559-14-4459	INA HUBARD, BOX 52 CAVES RD., OWINGSMILLS, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LIBEMIA
DUE TO (b): BRONCHO PNEUMONIA
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 9 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 22 JUNE, 1967, to 1 JULY, 19 67, that (I) (we) last saw the deceased alive on 1 JULY 1967, and that death occurred at 6:10 AM from the causes and on the date stated above.

22a. SIGNATURE: L.W. Johnson — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 1 July 67

22c. PHYSICIAN'S NAME (Type): LT L. W. JOHNSON, MC USNR — 22d. ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	7-5-67	Arlington National	Arlington Va.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR — DATE: JUL 5 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09017

CERTIFICATE OF DEATH

09016

1. PLACE OF DEATH
a. COUNTY: Anne Arundle Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundle Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 125 Cherrie Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lawrence Middle: W. Last: Cole
4. DATE OF DEATH: Month: July Day: 6 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1908
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles H. Cole
14. MOTHER'S MAIDEN NAME: Ida Mae Ridgaway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Betty Cole Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardio Renal Disease — Unknown
DUE TO
(c): Chronic Generalized Arthritis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-1-, 1967 to July 6, 1967 that (I) (we) last saw the deceased alive on July 4, 1967 and that death occurred at 7:14 A.M., from causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-8-67
22c. PHYSICIAN'S NAME (Type): Richard H. Hunt
22d. ADDRESS: 101 Cherry Lane Glen Burnie Md

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-9-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
23d. LOCATION (City or Town) (County) (State): Brooklyn, Md.

24. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1006 Brantley Ave.
25a. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1-17 Mulberry St - Dr Hunt

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09018 09017

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA-RURAL
d. STREET ADDRESS: 506 SYLVIEW DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARTHA Middle: C. Last: COLE

4. DATE OF DEATH: Month: JULY Day: 4 Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 3, 1893

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Coatsworth

14. MOTHER'S MAIDEN NAME: Lena Mae Bender

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO: 162-14-5597-D

17. INFORMANT: Mrs William Cole(Daughter in Law) #2 Address: Same as

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic Heart Disease — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-26 —, 1967, to 7-4, 1967, that (I) (we) last saw the deceased alive on 7/4 1967, and that death occurred at 2:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Hilary T. O'Herlihy M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-4-67

22c. PHYSICIAN'S NAME (Type): Hilary T. O'Herlihy M.D.

22d. ADDRESS: #5 Central Ave. S/W Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery

23d. LOCATION (City or Town) (County) (State): California, Penna.

24. FUNERAL DIRECTOR: Eugene B. Fleming ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: Jeanette Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09019 (09019)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie,
d. STREET ADDRESS: 7869 Crain Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: E. — Last: Connery
4. DATE OF DEATH: Month: 7 — Day: 11 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/31/1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Cleveland, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William D. Beynon
14. MOTHER'S MAIDEN NAME: Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Catherine Connery Box 285 Severn, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A. S. C. V. D. — INTERVAL BETWEEN ONSET AND DEATH: 1 weeks
DUE TO (b): Cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): T. A. I.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-25 19[illegible], to 7-11 1967, that (I) (we) last saw the deceased alive on 7-11 19 67, and that death occurred at 5 P. M, from the causes and on the date stated above.

22a. SIGNATURE: Robert Dabolins M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-13-67
22c. PHYSICIAN'S NAME (Type): Robert Dabolins
22d. ADDRESS: 400 Crain Hgwy. N. W. Glen Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/14/1967
23c NAME OF CEMETERY OR CREMATORY: St. Vincent's
23d. LOCATION (City, town or county) (State): Baltimore, Md. Md

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Raymond C. Fink Glen Burnie, Md.
25a. REC'D BY REGISTRAR — DATE: JUL 14 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

63019

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): North Arundel Hospital D.O.A.

2 USUAL RESIDENCE (Where deceased lived, if inst tut on Res dence before admission)
a. STATE: Maryland
b. COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d STREET ADDRESS: 626 Binstead Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First FRANK Middle FRAZIER Last COON III

4 DATE OF DEATH: Month July Day 16 Year 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 1-7-1934
9 AGE (In years last birthday): 33 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.C.G.
10b KIND OF BUSINESS OR INDUSTRY: U.S.NAVY.
11 BIRTHPLACE (State or foreign country): WASH. D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: FRANK F. COON JR.
14 MOTHER'S MAIDEN NAME: FLORENCE J. LITTLEFIELD

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Y S (If yes, give war or dates of service): 1952-1967
16 SOCIAL SECURITY NO: 214-30-6924
17. INFORMANT Address: MRS. HARRIET L. COON 626 FINSTEAD RD. GLEN BURNIE Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple fractures including: ribs: mandible and left femur
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
316.4
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18.): Subject driver in auto-auto collision
20c TIME OF INJURY Month, Day, Year Hour a.m.: 2:26 p.m. 7 16 19 67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.): Road
20f (City or town) (County) (State): Dorsey Rd. 1000 ft. w Wirth Rd.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.S. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: July 17, 1967

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF: JULY 20 /67
23c NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.
23d LOCATION (City or Town) (County) (State): ARLINGTON VA.

24 FUNERAL DIRECTOR: Frank Kelly Noon
ADDRESS: 322 S. HIGH ST. BALTO. Md.
25a REC'D BY REGISTRAR DATE: JUL 20 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

M

F

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09021

09033

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY AACO - MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) West-River.
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.O.A - Anne Arundel-Gen.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE VA. b COUNTY Arlington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington.
d STREET ADDRESS 1032 S. Edison St..
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Elmer Middle Lee Last Copenhaver
4 DATE OF DEATH Month 7 Day 17 Year 1967

5 SEX male
6 COLOR OR RACE white
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 12-14-20
9 AGE (In years last birthday) 46 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b KIND OF BUSINESS OR INDUSTRY Automobile
11 BIRTHPLACE (State or foreign country) Virginia
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Wade Copenhaver
14 MOTHER'S MAIDEN NAME Stella Lineweaver

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW II
16 SOCIAL SECURITY NO Yes N/A
17 INFORMANT Ethel Copenhaver (wife) Address same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH Minutes
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) See Overhead trying to start motor
20c TIME OF INJURY Hour a.m. p.m. Month Day, Year 7-15 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm factory, street office bldg., etc.) Chesapeake Bay
20f (City or town) (County) (State) AAco MD

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D
EXAMINER'S NAME (Type) E. L. Winchester.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city town or county)
22. DATE SIGNED 7-17-67

23a BURIAL, CREMATION REMOVAL (Specify) Removal-Burial
23b DATE THEREOF
23c NAME OF CEMETERY OR CREMATORY Cedarwood Cemetery
23d LOCATION (City or Town) (County) (State) Edinburg, Schenendoah Va.

24 FUNERAL DIRECTOR Bradley E. Hopping ADDRESS Hopping Funeral Home - Annapolis, Md.
25a. RECD BY REGISTRAR JUL 20 1967
25b REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09022

CERTIFICATE OF DEATH

09021

1. PLACE OF DEATH
   a. COUNTY: ANNE ARUNDEL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- GLEN BURNIE
   c. LENGTH OF STAY IN 1b: 8 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-PASADENA
   d. STREET ADDRESS: LAKESHORE DRIVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THERESA — Middle M. — Last COUNCILL

4. DATE OF DEATH: Month JULY — Day 31 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 3, 1893

9. AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): NEW YORK, NEW YORK

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Anton Smith

14. MOTHER'S MAIDEN NAME: Mary Kannengeiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Thomas C. Chase, Jr, 505 W. University

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Cerebro vascular accident — days
DUE TO (c): Essential Hypertension — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 23 1967, to July 31, 1967, that (I) (we) last saw the deceased alive on July 31 1967, and that death occurred at 9:24 A.M., from causes and on the date stated above.

22a. SIGNATURE: Max C Frank M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/31/67

22c. PHYSICIAN'S NAME (Type): MAX C FRANK M.D.

22d. ADDRESS: 425 SG Ritchie Hwy Glen Burnie Md 21061

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/2/67

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Ullrich Funeral Home 4210 Belair Road.

25a. REC'D BY REGISTRAR DATE: AUG 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judy

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G391 ??? /67 ph

09023 **CERTIFICATE OF DEATH** 09022

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 105 Maryland(Severn)
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 105 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: 105 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IRA — Middle K. — Last CROW
4. DATE OF DEATH: Month July — Day 25 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6 Dec. 1881
9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banking (ret)
10b. KIND OF BUSINESS OR INDUSTRY: Point Marion Bk.
11. BIRTHPLACE (County & State or foreign country): Fayette Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: (unknown) Crow
14. MOTHER'S MAIDEN NAME: (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO: 181-16-0805
17. INFORMANT: Mr. Ernest O. Knapp- 5, Maryland Ave. — Address: Severn, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Fibro Pneumonia
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Cardio Vasc. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1 day / 4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/21, 1967, to 7/25/67, that (I) (last saw the deceased alive on 7/22/1967, and that death occurred at 3:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: Joseph Lippert M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/25/67
22c. PHYSICIAN'S NAME (Type): JOSEPH LIPPERT, M.D.
22d. ADDRESS: Clinton, Maryland — Clinton Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/29/67
23c. NAME OF CEMETERY OR CREMATORY: EverGreen Memorial Pk.
23d. LOCATION (City or Town) (County) (State): Point Marion, Fayette, Pa.

24. FUNERAL DIRECTOR: Singleton Funeral Home/Glen Burnie, Maryland — ADDRESS: Robert P. Ware
25a. REC'D BY REGISTRAR DATE: JUL 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09024

CERTIFICATE OF DEATH

69023

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital		d. STREET ADDRESS: 730 Glenwood Street	e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Robert	Middle: Monroe	Last: CRUTCHLEY SR.	4 DATE OF DEATH	Month: July	Day: 1	Year: 19 67
5 SEX: Male	6 COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: August 27, 1888	9 AGE (In years last birthday): 78 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.	

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER	10b. KIND OF BUSINESS OR INDUSTRY: NEWSPAPER PRINTER	11 BIRTHPLACE (County & State, or foreign country): Maryland	12 CITIZEN OF WHAT COUNTRY? U. S.
13 FATHER'S NAME: THOMAS F. CRUTCHLEY		14 MOTHER'S MAIDEN NAME: ALICE CRUTCHLEY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16 SOCIAL SECURITY NO: 214-05-1162A	17 INFORMANT: Douglas N. Crutchley	Address: EDGEWATER Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus. — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from _____, 1961, to 7/1, 1967 that (I) (we) last saw the deceased alive on 7/1 1967, and that death occurred at 5:20 P.M. from causes and on the date stated above

22a SIGNATURE: [signature] M.D	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED: 7/3/67	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS		

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE THEREOF: JULY 5 1967	23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF CEM.	23d. LOCATION (City or Town) (County) (State): ANNAPOLIS Md.	
24 FUNERAL DIRECTOR: BEALL FUNERAL HOME	ADDRESS: 1212 West ST. ANNAPOLIS MD.	25a. RECD BY REGISTRAR DATE: JUL 6 1967	25b REGISTRAR'S SIGNATURE: Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 46

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09025

CERTIFICATE OF DEATH

GS024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

cc

F

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 2 Box 51 COMPTON
d. STREET ADDRESS: XXXXXXXXXXXX, XXXXXXXXXXXX, Maryland 21032
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Clement — Middle: L. — Last: Delahay

4 DATE OF DEATH: Month: 7 — Day: 21 — Year: 19 67

5 SEX: M

6 COLOR OR RACE: W

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: 9/27/ 95

9 AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Delahay

14. MOTHER'S MAIDEN NAME: XXXXXXXX Ida Drury

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 217-36-6673

17 INFORMANT — Address: Hospital Records Crownsville, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b): Secondary Chronic Brain Syndrome associated
DUE TO with generalized Arteriosclerosis
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/23/ , 1967 , to 7/21 , 1967 , that (I) (we) last saw the deceased alive on 7/21/ 19 67 , and that death occurred at 12:50 M, from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
M.D ATTENDING PHYS [ ] MED. DIRECTOR [X] STAFF PHYS [ ]

22b. DATE SIGNED: 7/21/67

22c. PHYSICIAN'S NAME (Type): L. Benedict, M.D.

22d. ADDRESS: Crownsville Maryland 21032

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: JULY 24, 1967

23c NAME OF CEMETERY OR CREMATORY: ST. FRANCIS XAVIER

23d LOCATION (City or Town) (County) (State): COMPTON, ST. MARY'S, MD.

24 FUNERAL DIRECTOR — ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09026

09025

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): O.O.A. - North Arundel Hosp.

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MD. — b. COUNTY: Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen
d. STREET ADDRESS: RR 11 - Box 118E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: Anna — Last: Ege
4. DATE OF DEATH: Month: 7 — Day: 12 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-10-1908
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Huthman
14. MOTHER'S MAIDEN NAME: Catherine Kampes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 214-50-1549
17. INFORMANT: McJohn Ege — Address: Box 118E-Rt 11 Pasadena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerosis
DUE TO (b): CVAmus
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): F. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
22. DATE SIGNED: 7-12-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/15/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven
23d. LOCATION (City or Town) (County) (State): Glen Burnie Md.

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave.
25a. RECD BY REGISTRAR — DATE: JUL 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09027 — 09026

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel Co. Crownsville, MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville, Maryland
   c. LENGTH OF STAY IN 1b: 9 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland
   b. COUNTY: A. A. Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
   d. STREET ADDRESS: P.O. Box 216 (Bost Blvd.)
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry; Middle: F.; Last: Faeser

4. DATE OF DEATH: Month: July; Day: 21; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/5/98

9. AGE (In years last birthday): 68 yrs
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired – owner

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Franklin Feeser

14. MOTHER'S MAIDEN NAME: Sarah Bonebrake

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
    (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 216-18-5561

17. INFORMANT: Anita Viola Feeser — Address: Severna Park, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Acuta Pulmonary Edema
    DUE TO
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    (b): Hypostatic Pneumonia
    DUE TO
    (c): Arteriosclerotic Cardiovascular Disease
    INTERVAL BETWEEN ONSET AND DEATH

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/21/67, 1967, to 7/21, 1967, that (I) (we) last saw the deceased alive on 7/21 1967, and that death occurred at 9:45 pm from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 7/22/67

22c. PHYSICIAN'S NAME (Type): Ludwig Benedict M.D.

22d. ADDRESS: Crownsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-25-67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Robert L. Barnard, Severna Park
ROBERT L. BARNARD — ADDRESS

25a. RECD BY REGISTRAR DATE: JUL 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09028

CERTIFICATE OF DEATH

09027

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] N. Linthicum
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #505 Heath Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arunde
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Linthicum
d. STREET ADDRESS: #505 Heath Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: Anna — Last: Gardner

4. DATE OF DEATH: Month: July — Day: 13 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 14, 1893

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Conrad Trimper

14. MOTHER'S MAIDEN NAME: Mary Gunther

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Mrs. Margaret Adams (Daughter) Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Coronary Thrombosis
DUE TO (b): H.B.P.D.
DUE TO (c): ———
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1 day / 10 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS A TOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 2, 1959 to Jan 13, 1967, that (I) (we) last saw the deceased alive on July 1, 1967, and that death occurred at ——— M, from causes and on the date stated above.

22a. SIGNATURE: Paul Schmford — M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/13/67

22c. PHYSICIAN'S NAME (Type): PAUL Schmford

22d. ADDRESS: 1301 Annapolis Rd

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 17 1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: R.V. Singleton — ADDRESS: Singleton Funeral Home Glen Burnie, Md.

25a. REGD BY REGISTRAR: JUL 17 1967 — DATE

25b. REGISTRAR'S SIGNATURE: Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

99030 — **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** — 68029

1 PLACE OF DEATH
a. COUNTY: AA Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY: N lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): O.O.A – North. ARUNDEL.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: RFD – Bx 302 A.I.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Edward — Middle: S — Last: Garpstas

4 DATE OF DEATH: Month: 7 — Day: 7 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 2/2/55

9 AGE (In years last birthday): 12 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school boy

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Baltimore, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Joseph J. Garpstas

14. MOTHER'S MAIDEN NAME: Alfreda M. Lehmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: ----

17 INFORMANT — Address: Mr. J. Garpstas (same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Drowning
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1794
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Drowning Glen Haven - Stony Creek

20c TIME OF INJURY: Hour p.m. — Month Day Year: 7-7 1967

20d INJURY OCCURRED: While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Stony Creek

20f (City or town) (County) (State): AA Co Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M.D

EXAMINER'S NAME (Type): E. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county):

22. DATE SIGNED: 7-7-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 11, 1967

23c NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.

23d LOCATION (City or Town) (County) (State): Ritchie Hgwy., A.A.Co., Md.

24 FUNERAL DIRECTOR — ADDRESS: George J. Gonce — 4001 Ritchie Hgwy., Baltimore

25a RECD BY REGISTRAR — DATE: JUL 12 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09029

CERTIFICATE OF DEATH

09028

1 PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Margarets
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 79 Conduit St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: C. — Last: GAY
4. DATE OF DEATH: Month: 7 — Day: 19 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-1-1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: Ret.
11. BIRTHPLACE (County & State, or foreign country): SEDALIA, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John H. Gay
14. MOTHER'S MAIDEN NAME: Ella Spaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Kingsbery W. Gay — Address: Bywater Rd. Annapolis, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
~~DUE TO~~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cardiovascular — INTERVAL BETWEEN ONSET AND DEATH:
~~DUE TO~~
(c): Renal — INTERVAL BETWEEN ONSET AND DEATH: 6 Yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to 7-20, 1967 that (I) (we) last saw the deceased alive on 7-3-1967, and that death occurred at 4 M, from causes and on the date stated above

22a. SIGNATURE: Paul McPhilley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-20-67
22c. PHYSICIAN'S NAME (Type): P M SHIPLEY
22d. ADDRESS: Annapolis Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 7-22-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City or Town) (County) (State): Bladensburg MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR: JUL 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09031 — 09039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): O.O.A-North-Arundel

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: AACO
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): ARNOLD-
d. STREET ADDRESS: 301-HASKell Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: L. — Last: Gilmour — Jr.
4. DATE OF DEATH: Month: 7 — Day: 17 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/25/19
9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: Coast Guard
11. BIRTHPLACE (State or foreign country): Del.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David L. Gilmour Sr.
14. MOTHER'S MAIDEN NAME: Lillie Mae Davis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Betty J.Gilmour, 301 Haskell Rd.Arnold, Address: Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Leonhardt M.D.
EXAMINER'S NAME (Type): E. Leonhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 7-17-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July, 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery.
23d. LOCATION (City or Town) (County) (State): Chestertown, Kent, Md.
24. FUNERAL DIRECTOR: Edward Fallon — ADDRESS: Millington Md.
25a. REC'D BY REGISTRAR: JUL 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09032

CERTIFICATE OF DEATH

C5031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 415 Crain Highway S. E.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 415 Crain Highway S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Giunta

4. DATE OF DEATH: Month: July — Day: 2, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 Feb 1895

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Self - Employed

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alphonse Giunta

14. MOTHER'S MAIDEN NAME: Rose Aversa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-32-0713

17. INFORMANT: Mrs. Catherine P. Giunta, same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hr

DUE TO (b): Acute Myocardial infarction — 12 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to 2 July 1967, that (I) (we) last saw the deceased alive on 2 July 19 67, and that death occurred at 1 P.M., from the causes and on the date stated above

22a. SIGNATURE: Paul Chang M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4 July 1967

22c. PHYSICIAN'S NAME (Type): Paul Chang, M. D.

22d. ADDRESS: Main Ave. S. E., Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5 July 1967

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Kirkley Funeral Home, Glen Burnie, Maryland

25a. RECD BY REGISTRAR DATE: JUL 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Snoga

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09033

CERTIFICATE OF DEATH

09032

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c LENGTH OF STAY IN 1b: 9 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLA ND — b COUNTY: ANNE ARUNDEL
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FORT GEORGE G. MEADE
d STREET ADDRESS: 1845-C PATTON DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SUZANNE — Middle ROCHELL — Last GRABILL
4. DATE OF DEATH: Month JULY — Day 12 — Year 19 67
5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 3, 1967
9 AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months — Days 9
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11 BIRTHPLACE (County & State or foreign country): Anne Arundel, Md
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Gilbert Grabill
14 MOTHER'S MAIDEN NAME: Freda Sue Napier

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): N/A
16 SOCIAL SECURITY NO.: N/A
17 INFORMANT: (father) — Address: Ft Geo G Meade
Gilbert Grabill, 1845-C Patton Drive Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Sepsis, generalized — INTERVAL BETWEEN ONSET AND DEATH
1630
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Hemorhagic Pneumonitis predominantly left
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory street office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that ☒ (this hospital) attended the deceased from 3 July, 19 67, to 12 July, 19 67, that ☒ (we) last saw the deceased alive on 12 July 19 67, and that death occurred at 9 a.m., from causes and on the date stated above.

22a. SIGNATURE: Fredk Nomura — M D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 12 July 1967
22c PHYSICIAN'S NAME (Type): FRED M. NOMURA, MAJ, MC
22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: July 17, 67
23c NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24 FUNERAL DIRECTOR: Harold L Wade, Lamel, Md
ADDRESS
25a REC'D BY REGISTRAR — DATE JUL 25 1967
25b REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09034 09035

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14 yrs. 2 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Unknown — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unknown
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): #16353 — First: Clarence — Middle — Last: Grant
4. DATE OF DEATH: Month: 7 — Day: 2 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: -/-/25
9. AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Carroll S.C.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Hospital Recorde

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Marked Anemia and IlectrolyTe Imbalance
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
293 x

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemiplegia; Mental Deficiency
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/29/ 19 53 to 7/2/ 19 67, that (I) (we) last saw the deceased alive on 7/2/ 19 67, and that death occurred at 3:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 7/3/67
22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-7-67
23c. NAME OF CEMETERY OR CREMATORY: Mt Cahary Cat
23d. LOCATION (City or Town) (County) (State): Brooklyn Md

24. FUNERAL DIRECTOR — ADDRESS: Elroy Wilson, 1000 Brantley Ave., Baltimore, Md
25a. REC'D BY REGISTRAR — DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09031

CERTIFICATE OF DEATH

09035

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shady Side
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: Alvin — Last: HALLOCK
4 DATE OF DEATH: Month: July — Day: 14 — Year: 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 1, 1896
9 AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b KIND OF BUSINESS OR INDUSTRY: Sea food
11 BIRTHPLACE (County & State, or foreign country): Shadyside Md.
12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: John Atwell Hallock
14. MOTHER'S MAIDEN NAME: Sarah Virginia Prout

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 214541673
17 INFORMANT: Address: LINA B. Niemiller, Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
413 x
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (~~this physician~~) attended the deceased from 7-14-67, 19___, to July 14, 1967, that (I) (~~and~~) last saw the deceased alive on July 14, 19 67, and that death occurred at 1:00 P.M., from causes and on the date stated above.

22a SIGNATURE: A. T. Allen
M.D. ATTENDING PHYS XX MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-15-67
22c PHYSICIAN'S NAME (Type): A. T. Allen, M.D.
22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: July 16 1967
23c NAME OF CEMETERY OR CREMATORY: Ridgely
23d LOCATION (City or Town) (County) (State): Ridgely Md
24. FUNERAL DIRECTOR: Bernard Hardesty — ADDRESS: Ridgely Md
25a. REC'D BY REGISTRAR DATE: JUL 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Gregg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09036

CERTIFICATE OF DEATH

63035

1 **PLACE OF DEATH**
a. COUNTY: Arne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 yr. 6 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing Home, 900 Van Buren St.

2 **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr.Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
d. STREET ADDRESS: 4214 - 53d Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First: Millard — Middle: F. — Last: Handy

4 **DATE OF DEATH**: Month: July — Day: 21, — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6/25/1897

9 AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): D.C.Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11 BIRTHPLACE (County & State, or foreign country): Wash.,D.C.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George K. Handy

14. MOTHER'S MAIDEN NAME: Jenny Combs

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO.: 578-62-1614

17 **INFORMANT**: T Mrs. C.Rose Notley - Dr., (Niece) Address 1404-Highland Ave., Silver Spr1,Md.

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ~~Arteriosclerotic Heart Disease~~
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 2 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ~~Influenza from Cold~~

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from ~~January~~ 19 67 to ~~July~~ 19 67, that (I) (we) last saw the deceased alive on ~~July~~ 19 67, and that death occurred at 6:05 P.M. from causes and on the date stated above.

22a SIGNATURE: ~~Edward Beck~~ M.D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type)

22d ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7/24/67

23c NAME OF CEMETERY OR CREMATORY: Mt.Olivet Cemetery

23d LOCATION (City or Town) (County) (State): Wash.,D.C.

24 FUNERAL DIRECTOR: Nalley's Funeral Home Inc. ADDRESS Mt.Rainier Maryland

25a RECD BY REGISTRAR DATE JUL 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09037 **CERTIFICATE OF DEATH** 09036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: 350 Oakwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Anne — Middle: Marie — Last: Hefferman
4. DATE OF DEATH: Month: July — Day: 27 — Year: 1967
5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 2-25-90
9 AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: George Kelly
14 MOTHER'S MAIDEN NAME: Mary Summers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 215-09-7689
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Septicemia generalized — hours
DUE TO
(c): Cerebrovascular Accident — minutes

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from July 27, 1967, to July 27, 1967, that (I) (we) last saw the deceased alive on July 27 1967, and that death occurred at 6:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/31/67
22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD
22d ADDRESS: 425 SE Hitchens Hwy Glen Burnie MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7-3-67
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d LOCATION (City or town) (County) (State): Balto Md
24. FUNERAL DIRECTOR: [signature] ADDRESS: Glen Beck, Md
25a. REC'D BY REGISTRAR DATE: AUG 1 1967
25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death If any delay is necessary, please execute the certificate, writing the word "pending" in pencil n Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1and2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09037

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 912 Windsor Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Lillian — Middle Frances — Last Hendricks

4 DATE OF DEATH: Month July — Day 18 — Year 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: October 16, 1892

9 AGE (In years last birthday): 74 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Home

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: John W. Ford

14 MOTHER'S MAIDEN NAME: Annie Bull

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16 SOCIAL SECURITY NO:

17 INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Infarction — Bilateral Pontomes-
DUE TO (b): Lacerated Liver — Ruptured Gall
DUE TO (c): Bronchi

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8days.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY (1) or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Struck by Auto

20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 7-10 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f (City or town) Arco (County) (State) MD

21 **I certify** that I took charge of the remains described above held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D

EXAMINER'S NAME (Type): Elmer G. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: July 18, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 21, 1967

23c NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cem.

23d LOCATION (City or Town): Annapolis (County): (State) Maryland

24. FUNERAL DIRECTOR: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

25b REC'D BY REGISTRAR DATE: JUL 21 1967

25c REGISTRAR'S SIGNATURE: Charles Judge

1-10

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09039 (duplicate)

09039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: AA co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North Arundel Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessop
d. STREET ADDRESS: Rt 175 - Box 419 A -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lottie. Middle: L. Last: Hogg S.

4 DATE OF DEATH: Month: 7 Day: 1 Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 9/22/07

9 AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Univ. of Maryland

11. BIRTHPLACE (State or foreign country): Orange Co., Virginia

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: John Deffmeyer

14 MOTHER'S MAIDEN NAME: Mary Elivabeth Peacher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): - - -

16 SOCIAL SECURITY NO: 217-01-1298

17 INFORMANT: Address: Mrs. Beatrice Redmiles, Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4501
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. Linhardt M D

EXAMINER'S NAME Type: F. Linhardt.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street city town, or county):

22. DATE SIGNED: 7-1-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: July 4, 1967

23c NAME OF CEMETERY OR CREMATORY: Good Shepherd Cemtery,

23d LOCATION (City or Town) (County) (State): Howard Co., Maryland

24 FUNERAL DIRECTOR: Harold S. Wally — ADDRESS: Laurel, Md

25a RECD BY REGISTRAR DATE: JUL 3 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) N
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09040 09639

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1207 Leonard Drive

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md b. COUNTY Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
d. STREET ADDRESS 1207 Leonard Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Girl Middle — Last Hoff

4. DATE OF DEATH Month July Day 10 Year 1967

5. SEX F
6 COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 10, 1967
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min 40

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Joseph Hoff
14. MOTHER'S MAIDEN NAME Evelyn Patricia Mauerham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17 INFORMANT Mother Address 1207 Leonard Rd

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 40 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Premature rupture) membranes
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-10 1967 to 7-10 1967 that (I) (we) last saw the deceased alive on 7-10 1967, and that death occurred at 9:15 A.M. from the causes and on the date stated above.

22a SIGNATURE Conrad Gordon M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22b DATE SIGNED July 10, 67
22c PHYSICIAN'S NAME (Type) Conrad Gordon M.D.
22d. ADDRESS 611 Park Ave. Balt. Md 21201

23a BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b DATE THEREOF 7, 10, 67
23c. NAME OF CEMETERY OR CREMATORY Medical Examiner's office
23d. LOCATION (City, town, or county) Balt. (State) Md. 700 East St.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
25a. REC'D BY REGISTRAR DATE JUL 18 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

837-1033

7-252.009

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09041 — 09042

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital
d. STREET ADDRESS: 179 Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: John — Middle: Benjamin — Last: HOLLIDAY, Jr.
4. DATE OF DEATH: Month: July — Day: 5 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 15, 1900
9 AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): ASSISTANT MANAGER
10b KIND OF BUSINESS OR INDUSTRY: THEATRE
11 BIRTHPLACE (County & State, or foreign country): ANNAPOLIS, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: JOHN B. HOLLIDAY
14. MOTHER'S MAIDEN NAME: SARAH KING

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO —
16 SOCIAL SECURITY NO: 214 05 0939A
17. INFORMANT: ANNIE KRANZ — Address: 3 MAYER AVE, BALTO. MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
331X
INTERVAL BETWEEN ONSET AND DEATH: 12 hours

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour o m p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) attended the deceased from 7/5, 1967, to July 5, 1967 that (I) last saw the deceased alive on July 5, 1967, and that death occurred at 10:55 PM, from causes and on the date stated above

22a SIGNATURE: Richard I. Hochman M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/6/67
22c PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d ADDRESS: 16 Murray Ave., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 7-8-67
23c NAME OF CEMETERY OR CREMATORY: ST. ANNES
23d LOCATION (City or Town) (County) (State): ANNAPOLIS H.H. MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons
ADDRESS: Annapolis, Md.
25a REC'D BY REGISTRAR DATE: JUL 10 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09042

CERTIFICATE OF DEATH

09041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
c. LENGTH OF STAY IN 1b: 27 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-PASADENA
d. STREET ADDRESS: RT 9 BOX 166 POWHATTEN BEACH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROLAND — Middle Howard — Last JAWORSKI

4. DATE OF DEATH: Month JULY — Day 31 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 28, 1896

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mech. (ret)

10b. KIND OF BUSINESS OR INDUSTRY: Balt. City

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ludwig Jaworski

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 214-48-1558

17. INFORMANT: Address 632 Old Annap. Rd. NE — Mr. Paul Jaworski Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Extensive Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Coronary Artery disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes, Adrenal insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7.4. , 1967 to 7.30 , 1967, that (I) (we) last saw the deceased alive on 7.30 1967, and that death occurred at 7.45 M, from causes and on the date stated above.

22a. SIGNATURE: H. Summers — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 31, 1967

22c. PHYSICIAN'S NAME (Type): HENRY SUMMERS

22d. ADDRESS: 1101 Patapsco Ave, Balto. 25 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: U.S. National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: R.V. SINGLETON — ADDRESS: GLEN BURNIE, MD.

25a. REC'D BY REGISTRAR DATE: AUG 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09043 — 1967 JUL 9 PM 3:21 7/25/67 KK — 09042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: A.A.CO — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and the nearest town): Glen Burnie
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. — North Arundel

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MD — b COUNTY: A.A.Co
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
d STREET ADDRESS: RR 2 - Box 876
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Howard — Middle: F. — Last: Johnson
4 DATE OF DEATH: Month: 7 — Day: 18 — Year: 1967
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11-30-48
9 AGE (In years last birthday): 18 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aluminum Worker
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: T. Claude Johnson
14 MOTHER'S MAIDEN NAME: Dorothy K. Witter

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 217-46-4288
17 INFORMANT — Address: T. Claude Johnson, same as 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Head Injury
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Auto burned over.
20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 7-18 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Highway
20f (City or town): / (County): A.A.Co (State): Md

21 I certify that I took charge of the remains described above filed an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 7/18/67

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 22 July 67
23c NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial
23d LOCATION (City or town) (County) (State): Elkridge, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Kirpley Funeral Home, Glen Burnie, Md.
25a RECD BY REGISTRAR DATE: JUL 21 1967
25b REGISTRAR'S SIGNATURE: Charles Yingst

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09044 — C9043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A - North Arundel

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 204
d. STREET ADDRESS: 3021 - Lylton Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

99

3 NAME OF DECEASED (Type or print): First: Letitia — Middle: G — Last: Johnson

4 DATE OF DEATH: Month: 7 — Day: 1 — Year: 19 67

5 SEX: F — 6. COLOR OR RACE: N — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: 7-31-55 — 9 AGE (In years last birthday): 11 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School — 10b KIND OF BUSINESS OR INDUSTRY: — 11 BIRTHPLACE (State or foreign country): Baltimore, Maryland — 12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: James A Johnson — 14. MOTHER'S MAIDEN NAME: Elsie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): — 16. SOCIAL SECURITY NO: no — 17. INFORMANT: Address: Mr James A Johnson 3021 Lylton Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Instl
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):
9298

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Swimming pool Accd.

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 7-1 19 67 — 20d INJURY OCCURRED While at work ☐ Not While at work ☒ — 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Belle Grove Road — 20f (City or town): — (County): Anne — (State): Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Linhardt M.D
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
22. DATE SIGNED: 7-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 7/5/67 — 23c NAME OF CEMETERY OR CREMATORY: Mt Auburn Cemetery — 23d LOCATION (City or Town): Baltimore (County): Md (State):

24 FUNERAL DIRECTOR: ADOLPHUS HALSTEAD — ADDRESS: 1206 W North Ave

25a REC'D BY REGISTRAR DATE: JUL 3 1967 — 25b REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C9045 — 69044

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 75 Clay St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ronald — Middle: Anthony — Last: JOHNSON

4. DATE OF DEATH: Month: July — Day: 15 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: July 13, 1967
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days: 1
IF UNDER 24 HRS: Hours: 14 — Min: 25

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Ronald Anthony Johnson
14. MOTHER'S MAIDEN NAME: Janice Patricia Church

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hyaline membrane disease
DUE TO
(c): Prematurity

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~XXXXXX~~) attended the deceased from July 13, 1967 to July 15, 1967 that (I) (~~saw~~) last saw the deceased alive on July 15, 1967, and that death occurred at 9:05 AM, from causes and on the date stated above.

22a SIGNATURE: Antonio M. Rivera M.D.
M.D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 20 Jul 67
22c. PHYSICIAN'S NAME (Type): Antonio M. Rivera, M.D.
22d ADDRESS: South RivMedCent., Edgewater, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/24/67
23c NAME OF CEMETERY OR CREMATORY: MORGUE
23d LOCATION (City or Town) (County) (State): Foot of Hall St

24. FUNERAL DIRECTOR — ADDRESS

25a REC'D BY REGISTRAR DATE: JUL 25 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09046

CERTIFICATE OF DEATH

09045

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 422 STATE St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Esther — Middle: C — Last: Jones

4. **DATE OF DEATH**: Month: July — Day: 28 — Year: 1967

5. **SEX**: F.

6. **COLOR OR RACE**: Wh.

7. **MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. **DATE OF BIRTH**: Aug. 20, 1884

9. **AGE** (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOME

10b. **KIND OF BUSINESS OR INDUSTRY**: Housewife

11. **BIRTHPLACE** (County & State, or foreign country): Baltimore, Md.

12. **CITIZEN OF WHAT COUNTRY?**: U.S.A.

13. **FATHER'S NAME**: John Crozier

14. **MOTHER'S MAIDEN NAME**: Katherine Kilbroughel

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): NO — (If yes give war or dates of service):

16. **SOCIAL SECURITY NO**: 220-07-1783

17. **INFORMANT**: D Roger C. Jones — Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
42.21
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o'm. a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1956, to July, 1967, that (I) (we) last saw the deceased alive on July 23 1967, and that death occurred at 3:44 M, from causes and on the date stated above

22a. SIGNATURE: John M. Layton — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/28/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-31-67

23c. NAME OF CEMETERY OR CREMATORY: CEDAR Bluff

23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR — ADDRESS: John M. Layton & Son Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

- 1 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09047 09046

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Annapolis
d. STREET ADDRESS: Box 174-Rt. 2 Tydings on the Bay
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CAROLYN — Middle B. — Last KNOEDLER

4. DATE OF DEATH: Month July — Day 4, — Year 1967.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 3, 1881.

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Gentry

14. MOTHER'S MAIDEN NAME: Jennie Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-44-2145

17. INFORMANT: Mr. Elmer L. Knoedler — Address: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
450.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,
DUE TO (b): Generalized arteriosclerosis — 1 year
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2/14, 1966, to 7/3, 1967, that (I) (~~we~~) last saw the deceased alive on 6/16 1967, and that death occurred at 6:00 M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/5/67

22c. PHYSICIAN'S NAME (Type): R. M. McLaughlin

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md 21122

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/7/67.

23c. NAME OF CEMETERY OR CREMATORY: Geo. Washington Mem. Park

23d. LOCATION (City, town or county) (State): Ridgewood, New Jersey.

24. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck, Inc. Balto. Md. 21214

25a. REG'D BY REGISTRAR — DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jenger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09048

CERTIFICATE OF DEATH

09047

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 19 Revell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Caroline — Last: KRAUZ

4. DATE OF DEATH: Month: July — Day: 15 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: January 1, 1879

9. AGE (In years last birthday): 88 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: PETER OLOF

14. MOTHER'S MAIDEN NAME: BRITTA JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: MRS MILDRED CROCKETT #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerosis Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b): 443X
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from MAY, 1964, to 15 JULY, 1967, that (I) (~~it~~) last saw the deceased alive on 14 July 1967, and that death occurred at 6:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D. — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 7/15/67

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.

22d. ADDRESS: 73 Franklin Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/18/1967

23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEM.

23d. LOCATION (City or Town) (County) (State): BALTIMORE MD.

24 FUNERAL DIRECTOR — **ADDRESS**: JOHN M. TAYLOR SON ANNAPOLIS MD

25a. REGISTRAR — DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09043 09043

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: ANNARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL CONVALESCENT CENTER 313 Hospital Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE
d. STREET ADDRESS: 1324 HILLMAN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: JOSEPH — Last: KURGAN
4. DATE OF DEATH: Month: 7 — Day: 17 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-28-09
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE - MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK KURGAN
14. MOTHER'S MAIDEN NAME: MARYANNA KRAWCZYK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 213-03-6256
17. INFORMANT: ANTHONY KURGAN — Address: 6305 FAIR OAKS AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Terminal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Carcinoma of Liver — 1 year
DUE TO
(c): Cachexia — 1 month

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED White at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/23, 1967, to 7/17, 1967, that (I) (we) last saw the deceased alive on 7/17 1967 and that death occurred at 6:55 PM from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/17/67
22c. PHYSICIAN'S NAME (Type): MAX C FRANK MD
22d. ADDRESS: 4 Ls SE Ritchie Hwy Glen Burnie Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7-20-67
23c. NAME OF CEMETERY OR CREMATORY: HOLY ROSARY CEM
23d. LOCATION (City or Town) (County) (State): BALTO MARYLAND

24. FUNERAL DIRECTOR: J. Edward Weber I.F.S.
ADDRESS: John M. Weber & Sons, Inc. 401 S Chester St.

25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09050

CERTIFICATE OF DEATH

09049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FT GEO G MEADE
c LENGTH OF STAY IN 1b: 8 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b COUNTY: PRINCE GEORGES
c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): LAUREL
d STREET ADDRESS: 8100 OGRMAN AVENUE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JESSIE — Middle M. — Last LACHER

4. DATE OF DEATH: Month JULY — Day 26 — Year 1967

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 28 July 1922

9. AGE (In years last birthday): 44 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — M.n

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b KIND OF BUSINESS OR INDUSTRY: U.S.Gov't

11 BIRTHPLACE (County & State, or foreign country): Waynesboro,Tennessee

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Strutts

14 MOTHER'S MAIDEN NAME: Ella Pope

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): N/A

16 SOCIAL SECURITY NO: 412-20-7053

17. INFORMANT — Address: Joe A.Lacher, Same as item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarction, Acute — INTERVAL BETWEEN ONSET AND DEATH: 8 Hours
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

4201

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 26 o, 1967, to July 26, 1967, that (I) (we) last saw the deceased alive on July 26 1967, and that death occurred at 1 P.M, from causes and on the date stated above

22a SIGNATURE: Jorge J. Ramirez — M.D — ATTENDING PHYS ☐ — MED DIRECTOR ☐ — STAFF PHYS ☒

22b. DATE SIGNED: July 26,1967

22c PHYSICIAN'S NAME (Type): JORGE J.RAMIREZ,CPT,MC

22d ADDRESS: KIMBROUGH ARMY HOSP,FT GEO G MEADE,MD

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 30 67

23c NAME OF CEMETERY OR CREMATORY: Phillips Cemetery

23d LOCATION (City or Town) (County) (State): Hampden County, Tenn.

24. FUNERAL DIRECTOR — ADDRESS: Harold S Wade, Laurel Md

25a REC'D BY REGISTRAR DATE: AUG 2 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39058

09051

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Rt. 1, Box 583
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
John	Maurice	MAYHEW	July	16	19 67

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Male	White		January 6, 1904	63 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
ret. plumber	US Gov't.	Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Augustus Mayhew	Margaret (last name unknown)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT
no	217-16-5738	Francis R. Mayhew 717 Spruce Drive Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b): Carcinoma of Lung — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Metastatic Carcinoma, Lung; Congestive Heart Failure

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/1, 1967, to 7/16, 1967, that (I) (we) last saw the deceased alive on 7/16 1967, and that death occurred at 9:00 A.M. from causes and on the date stated above

22a SIGNATURE: Edward S. Beck M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 7/17/67

22c. PHYSICIAN'S NAME (Type): Edward S. Beck, MD

22d. ADDRESS: Franklin St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	July 19, 1967	St. Mary's Cemetery	Annapolis Md.

24 FUNERAL DIRECTOR: Wesley E. Hopping — ADDRESS: Annapolis, Md.
HOPPING FUNERAL HOME

25a RECD BY REGISTRAR DATE: JUL 20 1967 — 25b REGISTRAR'S SIGNATURE: Charles Snoop

3 1 5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09052 Item 18 b Film G 391 8/4/67 jml

CERTIFICATE OF DEATH

09051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY A.A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena Box 411A Rt 9
d. STREET ADDRESS Ritchie Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Ernest Middle A Last McAllister
4 DATE OF DEATH Month 7 Day 24 Year 1967

5 SEX M.
6 COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-4-99
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge
10b KIND OF BUSINESS OR INDUSTRY A.A. Co.
11. BIRTHPLACE (County & State, or foreign country) Md.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Preston McAllister
14. MOTHER'S MAIDEN NAME Julia Bykerlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Family - Home Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO (b) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH (a) 30 minutes (b) 2 years (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1965 to July, 1967, that (I) (we) last saw the deceased alive on July 19 1967, and that death occurred at 5 P M, from causes and on the date stated above

22a SIGNATURE Robert I Levy M.D ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 7/25/67
22c PHYSICIAN'S NAME (Type) Robert I Levy M
22d ADDRESS 114 Medical Arts Bldg

23a BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF 7-28-67
23c NAME OF CEMETERY OR CREMATORY Glen Haven
23d LOCATION (City or town) Glen (County) (State)

24 FUNERAL DIRECTOR McCully - 237 Hapsco Ave. ADDRESS
25a. REC'D BY REGISTRAR DATE JUL 26 1967
25b REGISTRAR'S SIGNATURE

VR A15 (4) 25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09053 09053

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: P.O. Box-397
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ruth — Middle: Cecelia — Last: McCRARY

4. DATE OF DEATH: Month: July — Day: 25 — Year: 1967

5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 21, 1912
9 AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b KIND OF BUSINESS/OR INDUSTRY: Retail Store
11 BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Day
14 MOTHER'S MAIDEN NAME: Elsie Enders

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: Arthur McCrary Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~last saw~~) attended the deceased from May, 1967, to July 25, 1967, that (I) (~~saw~~) last saw the deceased alive on July 25, 1967, and that death occurred at 8:40 PM, from causes and on the date stated above.

22a. SIGNATURE: O. Linhardt M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-26-67
22c. PHYSICIAN'S NAME (Type): Elmer G. Linhardt, M.D.
22d. ADDRESS: 3 Chesapeake Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-28-1967
23c. NAME OF CEMETERY OR CREMATORY: Parklawn
23d. LOCATION (City or Town) (County) (State): Montgomery Co. Md.

24. FUNERAL DIRECTOR: John M. Taylor & Sons
ADDRESS: Annapolis, Md.
25a. RECEIVED BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: Beverly Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

29054 Items 8, 9 rim 6320 7/14/67 lde 05033

IMPORTANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 171

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
d. STREET ADDRESS: Box 171
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROLAND Middle: W. Last: McKNEW

4. DATE OF DEATH: Month: JULY Day: 7 Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 4, 1911

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter

10b. KIND OF BUSINESS OR INDUSTRY: self-empl. constr.

11. BIRTHPLACE (County & State, or foreign country): Anne Arundel Co.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles W. McKnew

14. MOTHER'S MAIDEN NAME: Martha Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-14-3174

17. INFORMANT Address: Mrs. Ruth V. McKnew - same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1967 to July 7, 1967, that (I) (we) last saw the deceased alive on June 30, 1967, and that death occurred at 11:5[illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: Barbara C. Palmer, M.D.

22b. DATE SIGNED: 7-8-67

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jul. 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial Cem.

23d. LOCATION (City, town or county) (State): Millersville, A.A. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Beverley L. Hopping

ADDRESS: HOPPING FUNERAL HOME - Annapolis, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 11 1967

25b. REGISTRAR'S SIGNATURE:

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20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39055

CERTIFICATE OF DEATH

69054

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE Maryland COUNTY Baltimore
14 3rd Ave. Landsdowne

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore Md. Glen Burnie
c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore Md.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel

d. STREET ADDRESS 14 3rd Ave. Landsdowne Md.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	Ellen	McLaughlin	July	18	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
F	W		8/12/06	60 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk B&O Railroad	Railroad	Maryland	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward M. Crocken	Anna Barland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
		Mrs. Lavorne Davis 95 H Rayford Dr., Pasadena, Md.

MED CAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Shock	
584X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Acute hemorrhage Pancreatitis	
DUE TO (c)	Acute cholecystitis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/16/67, 19___, to 7/18/67, 19___, that (I) (we) last saw the deceased alive on ___ 19___, and that death occurred at ___ M, from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
J.B. Ramirez	M.D	7/18/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J.B. RAMIREZ MD	3927 ANNAPOLIS RD Balto 27 1672 NORTHBOURNE RD Balto 12

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
7/21/67 Burial	7/21/67	Baltimore National	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Witzke F. D. - 4101 Edmondson Ave.	JUL 20 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09056 09055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 213 Crownsdale Circle

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: 213 Crownsdale Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle M. Last McMAHON
4. DATE OF DEATH: Month 7 Day 30 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-10-85
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Patrick Sinton
14. MOTHER'S MAIDEN NAME: Margaret Fahey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212074965
17. INFORMANT: J. Sinton Dougherty — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Ca Bladder
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1957, 19___, to 1967, 19___, that (I) (we) last saw the deceased alive on July 20 1967 and that death occurred at 4p M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Robert R. HAHN
22d. ADDRESS: P.O. BOX 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-2-67
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City, town or county) (State): Balto Md

24. FUNERAL DIRECTOR: Robert S. Barranco
ADDRESS: Severna Park, Md.
ROBERT S. BARRANCO

25a. REC'D BY REGISTRAR DATE: AUG 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #1 ... Page

09057 09056

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d STREET ADDRESS: 48 Cornhill St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha Middle Bishop Last MORGAN
4. DATE OF DEATH: Month July Day 13 Year 19 67
5 SEX: Female
6 COLOR OR RACE: Negro
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 9, 1890
9 AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ********
11. BIRTHPLACE (County & State, or foreign country): Annapolis Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME: William Bishop
14. MOTHER'S MAIDEN NAME: Anna Chew
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT Address: Norris H. Morgan-48 Cornhill St. Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Renal ischemia — 6 days
DUE TO (c): A.C.V.D. — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
4.121

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rt Hypernephroma & Nephrectomy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from July 7, 1967, to July 13, 1967, that (I) ~~(xx)~~ last saw the deceased alive on July 13 19 67, and that death occurred at 7:05 AM, from causes and on the date stated above.

22a SIGNATURE: Faye W Allen M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c PHYSICIAN'S NAME (Type): Faye W. Allen, M.D.
22d. ADDRESS: 62 Cathedtal St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: July 17-67
23c NAME OF CEMETERY OR CREMATORY: St. Anne's
23d. LOCATION (City or Town) (County) (State): Annapolis, Maryland
24 FUNERAL DIRECTOR ADDRESS: C.E.Hicks III Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39058

CERTIFICATE OF DEATH

39057

1 PLACE OF DEATH
a. COUNTY: X Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GlenBurnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GlenBurnie
d. STREET ADDRESS: 911 Rose Anne Rd. Glen Burnie, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: — Last: Mueller

4. DATE OF DEATH: Month: July — Day: 2, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 3-8-89

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Business

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant Business

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-30-3893

17. INFORMANT Address: GlenBurnie — Mr. Charles Mueller, 911 Rose Anne Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Unk
DUE TO (b): Carcinoma of Stomach — Months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
151X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/10, 19 67, to 7-2, 19 67, that I (we) last saw the deceased alive on 7-2 - 1967, and that death occurred at 7:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Hilary Jr. Mackey, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-2-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7-5-1967

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Cemetery

23d. LOCATION (City or Town) (County) (State): Howard County, Maryland

24. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard, 4107 Wilkens Ave. 21229

25a. RECD BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09059 — 3056

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): none Locust Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glen Burnie, Md.
d. STREET ADDRESS: Locust Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle Timothy — Last Neff, Jr.
4. DATE OF DEATH: Month July — Day 8 — Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 8, 1909
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Fire Department
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Neff Sr.
14. MOTHER'S MAIDEN NAME: Blanche Giles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 215-01-7593
17. INFORMANT: Mrs John Neff — Address: RFD1 Glen Burnie Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Myeloma
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
203Y
INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from September 5, 1961, to July 8, 1967, that (I) (~~we~~) last saw the deceased alive on July 7 1967, and that death occurred at 9A.M. from the causes and on the date stated above.

22a. SIGNATURE: R.M. McLaughlin — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/8/67
22c. PHYSICIAN'S NAME (Type): R.M. McLaughlin
22d. ADDRESS: 3708 Mountain Rd Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 11, 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
23d. LOCATION (City, town or county) (State): Ritchie Hgwy., A.A.Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: George J. Gonce — 4001 Ritchie Hgwy., Baltimore
25a. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09060

CERTIFICATE OF DEATH

09059

1 PLACE OF DEATH
a. COUNTY: AnneArundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 700 Americana Drive, Apt. 16

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 700 Americana Drive Apt. 16
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marian — Middle: Marian — Last: Oehm
4 DATE OF DEATH: Month: July — Day: 17, — Year: 19 67.

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1908.
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store
11 BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Beckenheimer.
14 MOTHER'S MAIDEN NAME: Margaret ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16 SOCIAL SECURITY NO: 214-20-2457
17 INFORMANT: Mr. Chris Oehm — Address: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/29, 1967, to 7/17, 1967, that (I) ~~(we)~~ last saw the deceased alive on 7/14, 1967 and that death occurred at 9:30 A M, from causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/19/67
22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.
22d. ADDRESS: 16 Murray Ave, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/19/67.
23c NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. — ADDRESS: Balto. Md. 21214
25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1B (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09061 — 09061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: A. A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. of A. Clubhouse

2 USUAL RESIDENCE (Where deceased lived, if institution Resident before admission)
a. STATE: Md
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 181 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Cassandra Middle W. Last Parker
4. DATE OF DEATH: Month 7 Day 29 Year 1967
5. SEX: Female
6. COLOR OR RACE: Col
7. MARR ED ☐ NEVER MARR ED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-1965
9. AGE (In years last birthday): 2 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gerald Parker
14. MOTHER'S MAIDEN NAME: Carolyn Lembley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Carolyn Lembley 181 West St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hemorrhage Pneumonia SDIT
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF M.D.: E. Linhardt
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 7-29-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-1-1967
23c. NAME OF CEMETERY OR CREMATORY: Pine Lawn
23d. LOCATION (City or Town) (County) (State): Glen Dale Md
24. FUNERAL DIRECTOR — ADDRESS: William Beall Annap Md
25a. RECD BY REGISTRAR — DATE: AUG 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09062 — 09062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: A A CO — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOR-North Arundel

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: A A CO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 8425 Ritchie Hwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

99

3. NAME OF DECEASED (Type or print): First: Paul — Middle: L — Last: Parker
4. DATE OF DEATH: Month: 7 — Day: 18 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR 13-1899
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Glen Burnie, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John R. Parker
14. MOTHER'S MAIDEN NAME: Sarah A. Myers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO: 212-26-7278
17. INFORMANT: Mrs. Mabel Parker (wife) — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
DUE TO (c):
4344
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f. (City or Town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D
EXAMINER'S NAME (Type): F. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county):
22. DATE SIGNED: 7/18/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: R. V. Singleton — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland
25a. RECD BY REGISTRAR — DATE: JUL 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09063

CERTIFICATE OF DEATH

09063

1 PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 147 Prince George St.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 147 Prince George St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EMIDIO — Middle — Last PASQUALUCCI
4 DATE OF DEATH: Month 7 — Day 30 — Year 1967

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 3-10-1875
9 AGE (In years last birthday): 92 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): R.R. Co.
10b KIND OF BUSINESS OR INDUSTRY: PENN. R.R. Co.
11 BIRTHPLACE (County & State, or foreign country): Italy
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: VINCENZO PASQUALUCCI
14 MOTHER'S MAIDEN NAME: [illegible] ANNA PONZIANI

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)
16 SOCIAL SECURITY NO.:
17 INFORMANT: VINCENZO PASQUALUCCI — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Acute Myocardial Failure
DUE TO (b): Auricular Fibrillation
DUE TO (c): Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7331
INTERVAL BETWEEN ONSET AND DEATH: Not Known

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED White at work ☐ Not White at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 7-28, 19[illegible] to 7-30, 1967, that (I) ~~(we)~~ last saw the deceased alive on 7-30 1967 and that death occurred at 3:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: W.P. Stephens — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 31 July 1967
22c. PHYSICIAN'S NAME (Type): W.P. STEPHENS
22d. ADDRESS: CORN HILL ST ANNAPOLIS

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 8-2-67
23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS
23d. LOCATION (City or Town) (County) (State): ANNAPOLIS MD.

24 FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a RECD BY REGISTRAR DATE: AUG 4 1967
25b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09064 **CERTIFICATE OF DEATH** 09064

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade, Md.
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kimbrough AH

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 409 Ritchie Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Sandra — Middle Renee — Last Pezzotta
4 DATE OF DEATH: Month July — Day 24 — Year 1967

5 SEX: Female
6 COLOR OR RACE: Cau
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 23 Jul 67
9 AGE (In years last birthday) 1/365 yrs — IF UNDER 1 YEAR: Months 0, Days 1 — IF UNDER 24 HRS: Hours 0, Min 0

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (County & State or foreign country): Anne Arundel, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Michael D. Pezzotta
14 MOTHER'S MAIDEN NAME: Dorothy J. Wynne

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes give war or dates of service) N/A
16 SOCIAL SECURITY NO: None
17 INFORMANT: 409 Ritchie Highway — Michael Pezzotta (f) Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature
762.7
DUE TO (b): Incomplete expansion of liungs bilateral, — 24 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): marked

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that ~~I~~ (this hospital) attended the deceased from 0800 23 Jul 1967, to 0115, 24 Jul 1967 that (I) (~~we~~) last saw the deceased alive on 0115, 24 Jul 1967, and that death occurred at 1:15 A.M., from causes and on the date stated above.

22a SIGNATURE: Capt Felix Alm't — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 7/29/67
22c PHYSICIAN'S NAME (Type): GELIX CONTE, CPT, MC
22d. ADDRESS: Kimbrough AH, Ft Geo G. Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/25/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetert
23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md. A. A.

24 FUNERAL DIRECTOR: Raymond C. Fink — ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR DATE: JUL 26 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09065

29065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c LENGTH OF STAY IN 1b: 15 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. C. Children's Center

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d STREET ADDRESS: 1661 Fort Davis Place, S. E.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James Middle: Pfarr Last:
4 DATE OF DEATH: Month: July Day: 5 Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-16-37
9 AGE (In years last birthday): 29 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Institutionalized
10b KIND OF BUSINESS OR INDUSTRY: ----
11 BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Robert Pfarr
14 MOTHER'S MAIDEN NAME: Catherine McHugh
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO.
17 INFORMANT Address: Children's Center Hospital, Laurel, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ~~Asphyxia~~ aspirated Hematemesis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Possible peptic ulcer
DUE TO
(c): Mental retardation - severe

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 16, 19 52, to July 5, 19 67, that (I) (we) last saw the deceased alive on July 5, 1967, and that death occurred at 7:50p M, from causes and on the date stated above.

22a. SIGNATURE: Margaret W. Mola M.D ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 7-6-67
22c. PHYSICIAN'S NAME (Type): MARGARET W. MOLA, M. D.
22d ADDRESS: Children's Center, Laurel, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7-7-67
23c. NAME OF CEMETERY OR CREMATORY: St. John's
23d LOCATION (City or Town) (County) (State): Johnstown Pa.
24 FUNERAL DIRECTOR: [illegible]
ADDRESS: [illegible]
25a REC'D BY REGISTRAR DATE: JUL 17 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09066 09066

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (20)
d. STREET ADDRESS: Rt.2 Box10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Oss — Last: Pinter
4. DATE OF DEATH: Month: 7 — Day: 13 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/27/80
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stephano Pinter
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): --
16. SOCIAL SECURITY NO: 218 09 2771
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Myocardial Infarction~~ H&C
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ASHD
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/23/ , 1966 , to 7/13/ , 1967 that (I) (we) last saw the deceased alive on 7/13 1967 , and that death occurred at 6.45 M, from causes and on the date stated above

22a. SIGNATURE: C. Dorkan M.D — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 7/13/67
22c. PHYSICIAN'S NAME (Type): C. Dorkan, M.D.
22d. ADDRESS: Crownsville, Maryland 21032

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/17/67
23c. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer
23d. LOCATION (City or Town) (County) (State): Baltimore City Md.

24. FUNERAL DIRECTOR: Bruzdzinski Funeral Home — ADDRESS: 1407 Eastern Ave. #21
25a. REC'D BY REGISTRAR DATE: JUL 17 1967
25b. REGISTRAR'S SIGNATURE: Charles Yaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09067 — 09067

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Collison Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Wilbur ~~XXXXX~~ — Middle: Dewey — Last: PLATT

4. **DATE OF DEATH**: Month: July — Day: 26 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 9, 1898

9. AGE (In years last birthday): ~~XX~~ 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): officer, ret. Lt.

10b. KIND OF BUSINESS OR INDUSTRY: US Navy

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: John S. Platt

14. MOTHER'S MAIDEN NAME: Prudence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): I & II

16. SOCIAL SECURITY NO: 212-34-5366T

17. **INFORMANT** Address: Emma E. Platt - same as #2 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/26, 19__, to 7/26, 19__, that (I) (we) last saw the deceased alive on 7/26 19__, and that death occurred at 6:13 P.M. from causes and on the date stated above.

22a. SIGNATURE: R. Brei — M.D — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: 7/28

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jul. 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City or Town) (County) (State): Ft. Meyer Va.

24. FUNERAL DIRECTOR: Hopping Funeral Home — ADDRESS: Beverly E. Hopping Annapolis, Md.

25a. RECD BY REGISTRAR DATE: AUG 1 1967

25b. REGISTRAR'S SIGNATURE: Florence Jaeger

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09068 **CERTIFICATE OF DEATH** 09068

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-GLEN BURNIE
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NORTH ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: NEW YORK — b. COUNTY: [redacted]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JAMAICA-LONG ISLAND #11432
d. STREET ADDRESS: 8907 169 ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA — Middle: — Last: POLLOCK

4. DATE OF DEATH: Month: JULY — Day: 4 — Year: 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 19, 1886
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel E. Distillator
14. MOTHER'S MAIDEN NAME: Pauline Moritz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 085-05-5853
17. INFORMANT: Mrs. Marion Witte — Address: 1191 Hillcrest Rd., Odenton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): A S H D
DUE TO (b): Pulmonary Emphysema
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-25, 1967 to 7/4, 1967 that (I) (we) last saw the deceased alive on 7/4/67 19___, and that death occurred at 1205 M, from causes and on the date stated above.

22a. SIGNATURE: Felix Gruneisen — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/4/67
22c. PHYSICIAN'S NAME (Type): Felix Gruneisen
22d. ADDRESS: 1119 Odenton Rd. Odenton Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Machtelah Cemetery
23d. LOCATION (City or Town) (County) (State): North Bergen Hudson N.J.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Hopping Funeral Home - Annapolis, Md. — Beverley E Hopping

25a. RECD BY REGISTRAR DATE: JUL 7 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09063 — **CERTIFICATE OF DEATH** — 09069

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 26.
c. LENGTH OF STAY IN 1b: 24-years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): None 910 Hilltop Road

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 26 (Orchard Beach)
d. STREET ADDRESS: 910 Hilltop Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Pope Sr
4. DATE OF DEATH: Month: July — Day: 5 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 21, 1895
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Retd - Baltimore City
11. BIRTHPLACE (County & State, or foreign country): Pittsburgh, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Pope
14. MOTHER'S MAIDEN NAME: Emma Schweinberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: 214-01-2322
17. INFORMANT: Mrs. William Pope — Address: Baltimore 26.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerosis — 3 years 6 months
DUE TO
(c): Cancer of the lung, Metastasis — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept 1, 1966 to July 5, 1967, that (I) (~~we~~) last saw the deceased alive on July 3 1967, and that death occurred at 6 A M from causes and on the date stated above.

22a. SIGNATURE: R.W. McLaughlin — M.O. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/5/67
22c. PHYSICIAN'S NAME (Type): R.W. McLaughlin
22d. ADDRESS: 3708 Mineral Rd Pasadena, Md. 21122

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/7/67
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
23d. LOCATION (City or Town) (County) (State): Glen Burnie A A Co.

24. FUNERAL DIRECTOR: McCulley Funeral Home
ADDRESS: Patapsco & 3rd St. 21225
25a. REC'D BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09070

MEDICAL-EXAMINER'S CERTIFICATE OF DEATH

09070

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: AA Co — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis-MD.
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA-Anne Arundel general

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: AA Co
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Tracys Landing
d. STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Angela — Middle: — Last: Powell

4 DATE OF DEATH: Month: 7 — Day: 25 — Year: 19 67

5 SEX: F

6 COLOR OR RACE: N

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Dec. 5-66

9 AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months 7, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Maryland (Or Hobbins Ang 6 Baltimore, Md.)

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: Charles Powell

14 MOTHER'S MAIDEN NAME: Margaret Chew

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT — Address: Charles Powell Tracys Landing AA Co Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Intracerebral Hemorrhage (5011) — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
525X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt MD

EXAMINER'S NAME (Type): E. Linhardt MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22 DATE SIGNED: 7/25/67

23a BURIAL, CREMATION, REMOVAL (Specify) ☒

23b DATE THEREOF: 8-1-67

23c NAME OF CEMETERY OR CREMATORY: Carters Ch. Cem

23d LOCATION (City or Town) (County) (State): Friendship AA. Md

24 FUNERAL DIRECTOR: Linthicum E. Everett — ADDRESS: Prince Frederick Md

25a RECD BY REGISTRAR DATE: AUG 3 1967

25b REGISTRAR'S SIGNATURE: Charles Jones

VR A15ME (5) 6M 1 67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 added 10/6/67 kk

C9071 **CERTIFICATE OF DEATH** C9071

1 PLACE OF DEATH
a. COUNTY: Anne Arundel. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6mths.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Crownsville State Hospital.

2 USUAL RESIDENCE (Where deceased lived, if institution Resident before admission)
a. STATE: Md.
b. COUNTY: A. A. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Barbara Middle: Low: PRATT

4 DATE OF DEATH: Month: July Day: 15 Year: 1967

5 SEX: F

6. COLOR OR RACE: W

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: 5/14/1890

9 AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: GROSS Samuel.

14. MOTHER'S MAIDEN NAME: Martha Gross

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 212-54-9961

17 INFORMANT Address: Rebecca Mayer Lothian Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pneumonia - hypostatic. — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Cerebral Thrombosis or Hemorrhage — 7 days
DUE TO (c): Arteriosclerotic Hypertensive Cardiovascular Disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome due to Cerebral Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 7/7, 19 67 to 7/15, 19 67, that (I) (we) last saw the deceased alive on 7/15, 19 67, and that death occurred at 4:25 AM, from causes and on the date stated above.

22a SIGNATURE: Lionel McHenry Mapp M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/15/67

22c PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, MD
22d ADDRESS: Crownsville State Hospital Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7-18-1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR: William Reese
ADDRESS: Glenn Md.

25a RECD BY REGISTRAR DATE: JUL 18 1967
25b REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the (hospital) director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39072 **CERTIFICATE OF DEATH** 39072

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Crownsville, State Hospital, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Betty — Middle: Elizabeth — Last: Rainey

4. DATE OF DEATH: Month: 7 — Day: 21 — Year: 1967

5. SEX: F
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/6/01
9. AGE (In years last birthday): 66 YRS
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Rainey
14. MOTHER'S MAIDEN NAME: Marita Luster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Address: Hospital Records, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): due to CVA
DUE TO
(c): Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/17, 1965, to 7/21, 1967, that (I) (we) last saw the deceased alive on 7/21, 1967, and that death occurred at 1:30 p M, from causes and on the date stated above.

22a. SIGNATURE: Louis McHenry Mapp
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/21/67
22c. PHYSICIAN'S NAME (Type): L. Mapp, M.D.
22d. ADDRESS: Crownsville, Maryland 21032

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 8-1-67
23c. NAME OF CEMETERY OR CREMATORY: U. Maryland
23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR: Wm. Reese, II — ADDRESS: Annapolis, Md.
25a. RECD BY REGISTRAR DATE: AUG 4 1967
25b. REGISTRAR'S SIGNATURE: Charles Fuge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09073 — CERTIFICATE OF DEATH — 09073

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEO G MEADE
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KIMBROUGH ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: 7313 LAUREL-BOWIE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant Male — Middle: — Last: RETTKE

4. DATE OF DEATH: Month: JULY — Day: 26 — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 JULY 1967
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 3 — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Md
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry Rettke
14. MOTHER'S MAIDEN NAME: Donna Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes give war or dates of service): N/A
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT — Address: Harry Rettke, Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): APNEA — INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs
DUE TO (b): PREMATURITY
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 25 July, 1967, to 26 July, 1967, that (X) (we) last saw the deceased alive on 26 July 19 67 and that death occurred at 2:30 a.m. from causes and on the date stated above.

22a. SIGNATURE: Felix Conte — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 26 July 1967
22c. PHYSICIAN'S NAME (Type): FELIX A. CONTE, CPT, MC
22d. ADDRESS: KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 7/27/67
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d. LOCATION (City or Town) (County) (State): Colmar Manor Md.

24. FUNERAL DIRECTOR: Hamill Funeral Home — ADDRESS: Laurel Md
25a. REC'D BY REGISTRAR — DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39074 — **CERTIFICATE OF DEATH** — 39074

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville STate Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: Crownsville, Maryland 21032
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: George — Middle: B. — Last: Rice

4. **DATE OF DEATH**: Month: 7 — Day: 27 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/17/96

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (County & State, or foreign country): Alantic City, New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rice

14. MOTHER'S MAIDEN NAME: Ethel Woolburt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.: 211-07-2898

17. INFORMANT — Address: Hospital Records, Crownsville Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Pneumonia
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. / X
   (b): ABS associated with alcoholic intoxication
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH:

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/15, 19 67, to 7/27, 1967, that (I) (we) last saw the deceased alive on 7/27, 19 67, and that death occurred at 8:30 a.m., from causes and on the date stated above.

22a. SIGNATURE: C. Dorkan, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 7/27/67

22c. PHYSICIAN'S NAME (Type): C. Dorkan, M.D.

22d. ADDRESS: Crownsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 8-1-67

23c. NAME OF CEMETERY OR CREMATORY: U. Maryland

23d. LOCATION (City or Town) (County) (State): Baltimore Maryland

24. FUNERAL DIRECTOR — ADDRESS: Wm Reese, II — Annapolis, md.

25a. RECD. BY REGISTRAR — DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: Beatrice Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09075

CERTIFICATE OF DEATH

09075

1 PLACE OF DEATH
a. COUNTY: A A Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Manor

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 316 Milton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula; Middle: A; Last: Roberts
4. DATE OF DEATH: Month: July; Day: 29; Year: 1967
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 25, 1866
9. AGE (In years last birthday): 100 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk
14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edgar Jennings — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
4221
DUE TO (b): Arteriosclerotic Cardiovascular disease — 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 26, 1966, to July 29, 1967, that (I) (we) last saw the deceased alive on July 7 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: R M Smith — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: July 29 1967
22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M. D.
22d ADDRESS: Hahn Professional Bldg., Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/31/67
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem
23d. LOCATION (City or Town) (County) (State): Balto Co Md

24. FUNERAL DIRECTOR — ADDRESS: McCully F H 237 Patapsco Ave 21225
25a. REC'D BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: J Charles Grogan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G361 7/26/67 kk

09076 09076

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore d. STREET ADDRESS: 947 Coleridge Rd. 21229 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: C. — Last: Robinson	4. DATE OF DEATH: Month: July — Day: 18 — Year: 1967
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 1-27-1898
9. AGE (In years last birthday): 69 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John W. Wiegand	14. MOTHER'S MAIDEN NAME: Kate Winn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16. SOCIAL SECURITY NO: None
17. INFORMANT: Mr. Lynnwood M. Robinson, 947 Coleridge Rd. — Address: 21229	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic Cardio Vascular Disease — 1 year
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/12, 1953 to 7/17, 1967, that (I) (we) last saw the deceased alive on 7/17, 1967, and that death occurred at 9:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: John P. Urlock Jr. M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7/19/67

22c. PHYSICIAN'S NAME (Type): Dr. John P. Urlock, Jr. — 22d. ADDRESS: 1227 Washington Blvd. VE 7-0179

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 7/22/67	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery	23d. LOCATION (City or Town): Baltimore	(County) (State): Md.
24. FUNERAL DIRECTOR: Howard H. Hubbard	ADDRESS: 4107 Wilkens Ave. 21229	25a. REG'D BY REGISTRAR DATE: JUL 20 1967	25b. REGISTRAR'S SIGNATURE: Charles Yaeger	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09077 **CERTIFICATE OF DEATH** 09077

1 **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL, ANNAPOLIS, MD.

2 **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD.
d. STREET ADDRESS: 37 NORTH GLEN AVE., ANNA., MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 **NAME OF DECEASED** (Type or print): First: ELIGIUS, SR. — Middle: LOUIS — Last: ROELLE, Sr.

4. **DATE OF DEATH**: Month: JULY — Day: 28 — Year: 19 67

5 SEX: MALE

6 COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 December 1885

9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Musician

10b. KIND OF BUSINESS OR INDUSTRY: US Navy Band

11. BIRTHPLACE (County & State or foreign country): Jasper, Indiana

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Joseph Roelle

14 MOTHER'S MAIDEN NAME: Catherine Roelle

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW I

16 SOCIAL SECURITY NO.: 215-48-5328

17 INFORMANT — Address: KATHRYNE R. KIRBY, 1608 VIRGINIA AVE., ANNA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARCINOMA OF RECTUM WITH METASTASIS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 7 July, 19 67, to 28 July, 19 67, that (I) (we) last saw the deceased alive on 28 July 19 67 and that death occurred at 1543 M, from causes and on the date stated above.

22a SIGNATURE: James J. Quinn — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: July 28, 1967
22c. PHYSICIAN'S NAME (Type): J. J. QUINN, LCDR MC USN
22d ADDRESS: NAVAL HOSPITAL, ANNAPOLIS, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug. 1, 1967
23c NAME OF CEMETERY OR CREMATORY: Arl. Nat'l Cemetery
23d LOCATION (City or Town) (County) (State): Ft. Myer, Va.

24 FUNERAL DIRECTOR: BEALL FUNERAL HOME, ANNAPOLIS, MD. — ADDRESS: Robert D. Beall Jr.
25a. REC'D BY REGISTRAR DATE: AUG 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Jaeger

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09078 — 09073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rt. 5, Box 232C - Magothy Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First JAMES — Middle C. — Last ROGERS

4 DATE OF DEATH: Month July — Day 14, — Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Jan. 15, 1914

9 AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b KIND OF BUSINESS OR INDUSTRY: Langenfelder & Son

11 BIRTHPLACE (State or foreign country): Wise Co., Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Raleigh Rogers

14 MOTHER'S MAIDEN NAME: Lucy Dingus

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give war or dates of service): WW II

16 SOCIAL SECURITY NO: 224 03 5690

17 INFORMANT: Mrs. Thelma Rogers (wife) — Address: Same As #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823.4
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): (driver of car) car went on shoulder, collided with guard rail & turned over. Subject thrown from car.

20c TIME OF INJURY Hour: 3:45 p.m. — Month, Day, Year: 7/14 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Street

20f (City or town) (County) (State): Baltimore -Anne Arundel-Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED. CA. EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 7/15/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 18, 1967

23c NAME OF CEMETERY OR CREMATORY: Hamm Cemetery

23d LOCATION (City or Town) (County) (State): Benner, Va.

24 FUNERAL DIRECTOR: P. Singleton — ADDRESS: Singleton Funeral Home, Glen Burnie, Maryland

25a REGISTERED BY REGISTRAR: DATE: JUL 17 1967

25b REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09073 09073

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Knollwood Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
d. STREET ADDRESS: 209 North Hammonds Ferry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Katherine — Middle: Rose — Last: Rohner

4 DATE OF DEATH: Month: July — Day: 10 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 6, 1886

9 AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never worked

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13 FATHER'S NAME: Henry Derrenberger

14 MOTHER'S MAIDEN NAME: Annie Herbst

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16 SOCIAL SECURITY NO.: 212-54-9794

17 INFORMANT — Address: Mr. Robert Wilson 113 Cedarcroft Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Carcinoma of breast with — INTERVAL BETWEEN ONSET AND DEATH: 2 year
170X
DUE TO (b): metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/12, 1966, to 7/10, 1967, that (I) (we) last saw the deceased alive on 7/5, 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Ray M Smith — M.D. — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 7/10/67

22c. PHYSICIAN'S NAME (Type): Ray M. Smith, M. D.

22d. ADDRESS: Hahn Professional Building, Severna Pk, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/13/1967

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

23d. LOCATION (City or Town) (County) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR: Wm. J. Tichnell & Son — ADDRESS: Balto. 2, Md.

25a. REC'D BY REGISTRAR — DATE: JUL 11 1967

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09080

CERTIFICATE OF DEATH

09092

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: BOX 623 XXXXXXXXXXXXXXX
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Genevieve — Middle: T. — Last: ROSE
4. DATE OF DEATH: Month: July — Day: 27 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 17, 1885
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Joshua Sank
14. MOTHER'S MAIDEN NAME: Eliza - - -
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Wm. A. Rose, Address: 7528 Carson Ave., 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Mon
DUE TO (b): Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p m 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-22, 1967, to 7-27, 19 67, that (I) (we) last saw the deceased alive on 7-27, 1967, and that death occurred at 11:05 A.M., from causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7-28-67
22c. PHYSICIAN'S NAME (Type): F.M. SHIPLEY
22d. ADDRESS: Annapolis Md

23a. BURIA., CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/31/67
23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEMETERY
23d. LOCATION (City or Town) (County) (State): BALTO., MD.
24 FUNERAL DIRECTOR ADDRESS: HOWARD H. HUBBARD 4107 WILKENS AVE., 21229
25a. REC'D BY REGISTRAR DATE: AUG 2 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09081

CERTIFICATE OF DEATH

09081

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d STREET ADDRESS: 1165 Madison St.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Edward — Middle: LeRoy — Last: RUTTER
4 DATE OF DEATH: Month: July — Day: 25 — Year: 19 67

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Dec. 28, 1892
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b KIND OF BUSINESS OR INDUSTRY: State of Md.
11 BIRTHPLACE (County & State, or foreign country): Bahto. Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Joseph Rutter
14. MOTHER'S MAIDEN NAME: Newton

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I
16 SOCIAL SECURITY NO: 214 03 1140A
17 INFORMANT: Ruth P. Rutter — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 13 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) ~~(this hospital)~~ attended the deceased from June, 1966, to 7/25, 1967, that (I) ~~(we)~~ last saw ~~the~~ deceased alive on 7/25 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a SIGNATURE: Richard L. Hochman — MD — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/26/67
22c PHYSICIAN'S NAME (Type): Richard I. Hochman, MD
22d ADDRESS: 16 Murray Ave, Annapolis, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-28-67
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn
23d LOCATION (City or Town) (County) (State): Bahto MD.

24. FUNERAL DIRECTOR: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
25a REC'D BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Groger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09082 09082

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 27 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mariea — Middle: Clorinda — Last: SALUZZO
4. DATE OF DEATH: Month: July — Day: 24 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 6, 1913
9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Australia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pietro Martinis
14. MOTHER'S MAIDEN NAME: Clorinda Mariea Ornella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 324-09-8772
17. INFORMANT: Bruno Saluzzo — Address: Harwood, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Ac. Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 20 min
DUE TO (b): Art. C. V. disease & Hypertension — yrs.
DUE TO (c): Ch. Nephritis — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/20/, 19 67, to 7/23/, 19 67 that (I) (we) last saw the deceased alive on 7/23/ 19 67 and that death occurred at 3:20 A.M., from causes and on the date stated above

22a. SIGNATURE: Manuel K Kiriakos M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): M. E. KLAWANS
22d. ADDRESS: 31 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/27/67
23c. NAME OF CEMETERY OR CREMATORY: Our Lady of Sorrows
23d. LOCATION (City or Town) (County) (State): Owensville, Md

24. FUNERAL DIRECTOR: T A Hardesty — ADDRESS: Galesville Md

25a. REC'D BY REGISTRAR DATE: AUG 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Yeager

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09083

09083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Deale
c LENGTH OF STAY IN 1b: 7 yrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deale
d. STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle A. — Last SANFORD

4 DATE OF DEATH: Month July — Day 17, — Year 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 3/22/09

9 AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Owner

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Montross VA

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Charles L. Sanford

14 MOTHER'S MAIDEN NAME: Susie Ann Foxwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO: 578057358

17 INFORMANT: Address: Emmd Sanford Deale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
4221
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: 7/18/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-21-67

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d LOCATION (City or Town) (County) (State): Washington DC

24 FUNERAL DIRECTOR: Bernard Hardesty — ADDRESS: Salisbury Md

25a RECD BY REGISTRAR DATE JUL 21 1967

25b REGISTRAR'S SIGNATURE: Juliette Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09084 09084

1. PLACE OF DEATH
a. COUNTY A-A-Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b 1 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 Severn River Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY A-A-Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS 111 Severn River Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Robert Middle H Last SAPP.
4. DATE OF DEATH Month 7 Day 4 Year 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-5-39
9. AGE (In years last birthday) 27 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Westinghouse
11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME Harold B. Sapp
14. MOTHER'S MAIDEN NAME Grace Nemphos
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give wars or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Harold B. Sapp Address RD 2 Ithaca N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub arach and cerebral clot — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b) Coma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound chest
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 7/4 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) AACo (State) MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. Linhardt
EXAMINER'S NAME (Type) E. Linhardt
CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED 7-4-67.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-10-67
22c. NAME OF CEMETERY OR CREMATORY East Lawn Cem.
22d. LOCATION (City, town, or county) Ithaca (State) N.Y.

23. FUNERAL DIRECTOR ADDRESS Robert S. Barranco, Severna Park, Md.
ROBERT S. BARRANCO
24a. REC'D BY REGISTRAR DATE JUL 10 1967
24b. REGISTRAR'S SIGNATURE J. Charles Jutze

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09085 **CERTIFICATE OF DEATH** 09085

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 49 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Baltimore~~ Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 513 Annabel Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: T. — Last: Schuman

4. DATE OF DEATH: Month: July — Day: 5 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-23-03

9. AGE (In years last birthday): 63

IF UNDER 1 YEAR: Months: 9 — Days: 12
IF UNDER 24 HRS: Hours: — M.n.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Benik

14. MOTHER'S MAIDEN NAME: Brigitta Waitkas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. W. Raymond Schuman — Address: 513 Annabel Ave. 21225

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO (b): Generalized Metastasis
DUE TO (c): Carcinoma Pancreas, Dx 6 Mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
'72 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/17, 1967, to 7/5, 1967, that (I) (we) last saw the deceased alive on 7/5, 1967, and that death occurred at 12:20 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/5/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/8/67

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Brooklyn A. A. Co. Md.

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave. 21225

25a. RECD BY REGISTRAR DATE: JUL 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

22086 (22086)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25, Md.
d. STREET ADDRESS: Nann Ave., Edmar Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: I. — Last: Schupbakk
4. DATE OF DEATH: Month: July — Day: 19 — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-6-88
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Glenelg, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ivan Day
14. MOTHER'S MAIDEN NAME: Isabelle Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Patricia Warden — Address: Edmar Trailer Park Balto 25, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Generalized
DUE TO (b): Carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to 7/7, 1967, that (I) (we) last saw the deceased alive on 7/19 1967, and that death occurred at 8:05 P.M. from causes and on the date stated above.

22a. SIGNATURE: Guillermo A. Jimenez M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-22-67
23c. NAME OF CEMETERY OR CREMATORY: Lakeview Park
23d. LOCATION (City or Town) (County) (State): Randallstown Balto Md.
24. FUNERAL DIRECTOR: Higinbotham-Slack Funeral Home — ADDRESS: Ellicott City Md
25a. REC'D BY REGISTRAR DATE: JUL 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 20 Film 391 8-4-67 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09087 Item #2c & d Film #0391 8/3/67 ph 09087

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bay Manor Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: AnneArundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Annapolis Rivi
d. STREET ADDRESS: Bay Manor Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Elizabeth — Middle: C. — Last: Sharkey

4. DATE OF DEATH: Month: July — Day: 22 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Oct. 9 1882

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Brooklyn, N.Y.

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Michael Chadwick

14 MOTHER'S MAIDEN NAME: Elizabeth Murray

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17. INFORMANT: Mrs C. Sharkey — Address: Minneapolis Minn.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): INANITION — INTERVAL BETWEEN ONSET AND DEATH: 2 MONTHS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): FRACTURE OF HIP (LEFT, 10 JULY 67) — 2 WEEKS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCEROSIS, GENERAL & CEREBRAL WITH SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Debilitated, patient untied restraints, slipped when getting from bed and fell

20c TIME OF INJURY Month, Day, Year: Hour: 1.15 p.m. Jul 10 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Nursing home

20f (City or town) (County) (State): AA

21. **I certify** that (I) (this hospital) attended the deceased from 10 JULY, 1967 to 22 JULY, 1967, that (I) (we) last saw the deceased alive on 22 JULY 1967, and that death occurred at 10:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Charles W. Kinzer M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 24 JULY 67

22c PHYSICIAN'S NAME (Type): CHARLES W. KINZER, M.D.

22d ADDRESS: 16 MURRAY AVE., ANNAPOLIS, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-25-1967

23c NAME OF CEMETERY OR CREMATORY: St. Marys

23d LOCATION (City or Town) (County) (State): Annapolis Md.

24. FUNERAL DIRECTOR — ADDRESS: John W. Taylor & Sons Annapolis, Md.

25a REC'D BY REGISTRAR DATE: JUL 31 1967

25b REGISTRAR'S SIGNATURE: Charles Jaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1 H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09088 **CERTIFICATE OF DEATH** 09088

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6/19/65
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md — b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 968 N Chester Street
e. S RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: SUSIE — Middle: / — Last: SHAVERS

4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/18/97

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Moses Jones

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): hypertensive cardio vascular disease — vrm [illegible]
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/19/65, 19__ to 7/24/67, 19__, that (I) (we) last saw the deceased alive on 7/24/67 19__, and that death occurred at 8:15 AM, from causes and on the date stated above.

22a. SIGNATURE: H Benedict M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐

22b. DATE SIGNED: 7/25/67

22c. PHYSICIAN'S NAME (Type): H. BENEDICT M.D.

22d. ADDRESS: Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-1-67

23c. NAME OF CEMETERY OR CREMATORY: Baltimore Nat Cem

23d. LOCATION (City or Town) (County) (State): Baltimore Md

24. FUNERAL DIRECTOR: Eloy O Wilson — ADDRESS: Brantley Inc

25a. REC'D BY REGISTRAR DATE: AUG 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09089

CERTIFICATE OF DEATH

09089

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-1, Box-281Z
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Maebelle — Middle Colingwood — Last SHIES

4 DATE OF DEATH: Month July — Day 19 — Year 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8 DATE OF BIRTH: May 13, 1900

9 AGE (In years last birthday): 67 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William J Collingwood

14. MOTHER'S MAIDEN NAME: Jennie Wilson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO. 218-34-5762P

17 INFORMANT: John W. Shiles — Address: Edgewater, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Kidney Breakdown
DUE TO (b): uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m p.m 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~Accordingly~~) attended the deceased from _____, 19 _____, to July 19, 1967, that (I) (~~did~~) last saw the deceased alive on July 19, 19 67, and that death occurred at 8:05 AM M, from causes and on the date stated above.

22a. SIGNATURE: Elmer G. Linhardt M.D.
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/24/67

22c. PHYSICIAN'S NAME (Type): Elmer G. Linhardt, M.D.

22d. ADDRESS: 3 Chesapeake Ave., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b DATE THEREOF: 7/21/67

23c NAME OF CEMETERY OR CREMATORY: Lee Crematory

23d LOCATION (City or Town) (County) (State): Washington, D.C

24. FUNERAL DIRECTOR: T.A. Hardesty & Son — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE JUL 21 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

68090 68090

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Glen Burnie
d. STREET ADDRESS: Rt-1, Box-153A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evan — Middle: Zachary — Last: SMITH
4. DATE OF DEATH: Month: July — Day: 19 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1967
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: David Sylvester Smith
14. MOTHER'S MAIDEN NAME: Gloria M. Howard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: David S. Smith — Address: Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiovascular Collapse
DUE TO (b): Immaturity
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7714 X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from July 19, 1967, to July 19, 1967, that (I) last saw the deceased alive on July 19, 1967, and that death occurred at 11:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Stuart M. Christhilf M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-20-67
22c. PHYSICIAN'S NAME (Type): Stuart M. Christhilf, M.D.
22d. ADDRESS: 69 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
23d. LOCATION (City or Town) (County) (State): Annapolis Md.
24. FUNERAL DIRECTOR: William Reese — ADDRESS: Annapolis Md.
25a. REGISTRAR: — DATE: JUL 27 1967
25b. REGISTRAR'S SIGNATURE: Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09091

Items 5-6-7 Filed 8:30 7/14/67 kk

09091

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: 33 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. Gen Hosp

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie md.
d. STREET ADDRESS: 1220 Cathedral Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Turner — Middle: Wilson — Last: Smith

4 DATE OF DEATH: Month: 7 — Day: 9 — Year: 67 19

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 4-27-18

9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b KIND OF BUSINESS OR INDUSTRY: Rail Road

11 BIRTHPLACE (County & State, or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Smith

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): 2

16. SOCIAL SECURITY NO.: 256-14-7386

17 INFORMANT: Mrs. Edward Schneider (Helen J. Smith)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Generalized Malignancy
DUE TO (b): Hypernephroma
DUE TO (c): C.V.D. & Cardiac
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 180X

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19__ to 1967, 19__, that (I) (we) last saw the deceased alive on 7-8-67 19__, and that death occurred at 12:35 A.M., from causes and on the date stated above.

22a SIGNATURE: Robert R. Holm M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): Robert R. Haffy

22d. ADDRESS: P.O. Box 73 Severna Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-11-67

23c NAME OF CEMETERY OR CREMATORY: Trinity Church Cemetery

23d. LOCATION (City or Town) (County) (State): Odenton Md.

24. FUNERAL DIRECTOR: Robert Ware
ADDRESS: Singleton Funeral Home Glen Burnie md

25a RECD BY REGISTRAR DATE: JUL 12 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09092 09092

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Field	Entry
1. PLACE OF DEATH a. COUNTY	Anne Arundel, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Annapolis
c. LENGTH OF STAY IN 1b	1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Anne Arundel General Hosp.
2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	Maryland
b. COUNTY	Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RURAL Davidsonville
d. STREET ADDRESS	Covington Farm
e. IS RESIDENCE ON A FARM?	YES [X] NO [ ]
3. NAME OF DECEASED (Type or print) First / Middle / Last	Lester Joseph SNODGRASS
4. DATE OF DEATH Month / Day / Year	July 22, 1967
5. SEX	Male
6. COLOR OR RACE	Cauc.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	Widowed
8. DATE OF BIRTH	April 19, '14
9. AGE (In years last birthday)	53 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Die worker
10b. KIND OF BUSINESS OR INDUSTRY	Plastics
11. BIRTHPLACE (County & State, or foreign country)	Rose Hill, Virginia
12. CITIZEN OF WHAT COUNTRY?	U. S. A.
13. FATHER'S NAME	James Snodgrass
14. MOTHER'S MAIDEN NAME	RETTIE SNODGRASS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No
16. SOCIAL SECURITY NO.	230-14-0159
17. INFORMANT / Address	Son, James V. Snodgrass, 91 West St. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Inanition	2 month
DUE TO (b)	Carcinoma (oat cell type) of lung	1 year
DUE TO (c)	- - - - -	- - -

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 13, 1967, to July 22, 1967, that (I) (we) last saw the deceased alive on July 22, 1967, and that death occurred at 8:20 PM, from causes and on the date stated above.

22a. SIGNATURE Charles W. Kinzer M.D. ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED July 23, 1967

22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.

22d. ADDRESS 16 Murray Av., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JULY 25, 1967	HAMILTON CEM.	LEE COUNTY VA.

24. FUNERAL DIRECTOR Robert G. Beall Jr. BEALL FUNERAL HOME ADDRESS 1212 WEST ST. ANNA., Md.

25a. REC'D BY REGISTRAR DATE JUL 26 1967

25b. REGISTRAR'S SIGNATURE [illegible signature]

VR A15 (4)
25M 1/67

53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09093 09093

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 97 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: — Last: SNYDER

4. DATE OF DEATH: Month: July — Day: 16 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. October 15, 189[illegible]

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State or foreign country): Lithuania XXXXXXXX

12. CITIZEN OF WHAT COUNTRY? XXXXX

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 216-46-0156T

17. INFORMANT: Mrs. Jack Lucas — Address: 8709 McClair Drive Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 16 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Ac. Pulmonary edema — 1 day
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old myocardial infarction. Chr. Nephritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/3, 19 67, to 7/16, 19 67, that (I) (we) last saw the deceased alive on 7/16, 19 67, and that death occurred at 5:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Morris Klemons M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/18/67

22c. PHYSICIAN'S NAME (Type): M. E. KLAWANS, M.D.

22d. ADDRESS: 31 SOUTHGATE AVE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel

23d. LOCATION (City or Town) (County) (State): Annapolis Anne Aru. Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping - HOPPING FUNERAL HOME - Annapolis, Md. — ADDRESS: Beverley E. Hopping

25a. RECD BY REGISTRAR DATE: JUL 20 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

69094 (top) 69091

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completed in by the funeral director, within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
c. LENGTH OF STAY IN 1b: 25
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 206 Haile Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 206 Haile Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jake; Middle: Emmanuel; Last: Sowers

4. DATE OF DEATH: Month: July; Day: 5; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 27, 1914

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Seaview Const. Co.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jake E. Sowers

14. MOTHER'S MAIDEN NAME: Rose A. Tutwiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-07-8587

17. INFORMANT: Mrs. Margaret B. Sowers — Address: 206 Haile Ave. 21225

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis
DUE TO (b): Ca of esophagus.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1.5.66, 19.., to 7.5...., 1967 that (I) (we) last saw the deceased alive on 7.5. 1967 and that death occured at 10 AM, from the causes and on the date stated above

22a. SIGNATURE: H G Summers

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): H G Summers — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 1101 Patapsco Ave Balto Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge — ADDRESS

23d. LOCATION (City, town or county) (State): Elkridge Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons North Pa. Aves. 17-MB

25a. REC'D BY REGISTRAR — DATE: JUL 7 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09095 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09095

1 PLACE OF DEATH
a. COUNTY A.A. Rt 2 Box 105 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skidmore
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 2 Box 105

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Md b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skidmore
d. STREET ADDRESS Rt 2 Box 105
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Clifton Middle: Stevens Last:
4. DATE OF DEATH Month: 7 Day: 16 Year: 67 19
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/1/1910
9. AGE (In years last birthday) 57 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George Stevenson
14. MOTHER'S MAIDEN NAME Mary Snowden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address: Katherine Murray Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) Congestive heart failure — years
DUE TO
(c) Arteriosclerosis — Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH —
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles H. Wirth M.D.
EXAMINER'S NAME (Type) Charles H. Wirth, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)
22. DATE SIGNED 7/16/67

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 7-19-1967
23c. NAME OF CEMETERY OR CREMATORY Broadneck
23d. LOCATION (City or Town) (County) (State) St. Margarets Md.
24. FUNERAL DIRECTOR ADDRESS William Reese Annapolis Md.
25a. RECD BY REGISTRAR DATE JUL 18 1967
25b. REGISTRAR'S SIGNATURE Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If the delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, Page 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C9096 C9096

1 PLACE OF DEATH
a COUNTY A.A. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS MD.
c LENGTH OF STAY IN 1b
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MD. b COUNTY A.A.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHERWOOD FOREST
d STREET ADDRESS 534 LITTLE JOHN HILL
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First CECILE Middle INEZ Last TOWNSEND
4 DATE OF DEATH Month JULY Day 21 Year 19 67

5 SEX F
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 12-19-1872
9 AGE (In years last birthday) 94 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEWIFE
10b KIND OF BUSINESS OR INDUSTRY HOME
11 BIRTHPLACE (County & State, or foreign country) E. Boston MASS.
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME JOHN COBURN
14. MOTHER'S MAIDEN NAME ELIZA (UNK)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) —
16. SOCIAL SECURITY NO.
17 INFORMANT Address MRS. DOUGLAS F. MINER #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Arteriosclerosis
DUE TO
(b) Cardiovascular
DUE TO
(c) Renal
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-28, 19 67 to 7-21, 19 67 that (I) (we) last saw the deceased alive on 7-21 19 67, and that death occurred at 7:50 P.M. from causes and on the date stated above

22a. SIGNATURE J.M. Phipps M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED 7-24-67
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY
22d. ADDRESS Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF 7-25-67
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemt.
23d LOCATION (City or Town) EVERETT (County) (State) MASS

24 FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis, Md.
25a. REC'D BY REGISTRAR DATE JUL 24 1967
25b REGISTRAR'S SIGNATURE J. Chandler Judge

Items 18&21 Film 392
9-14-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 FOR STATE HEALTH DEPT. M

09097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09098

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

PLACE OF DEATH a COUNTY: ANNE ARUNDEL — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE: Maryland b COUNTY: ANNE ARUNDEL
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Glen Burnie~~XXXXXXX~~ — c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXXXXX~~ Gambrills
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): NORTH ARUNDEL HOSPITAL	d STREET ADDRESS: Dairy Farm Road — e S RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print)	First: JEFFERY	Middle: M.	Last: TURNER	4 DATE OF DEATH	Month: July	Day: 26,	Year: 19 67	
5 SEX: Male	6 COLOR OR RACE: White	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: August 9, 1965	9 AGE (In years last birthday): 1-11mths.	IF UNDER 1 YEAR Months: 11	Days	IF UNDER 24 HRS Hours	Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b KIND OF BUSINESS OR INDUSTRY: ----------	11 BIRTHPLACE (State or foreign country): Baltimore, Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER'S NAME: Harry B. Turner		14 MOTHER'S MAIDEN NAME: Ann Kadingo	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): ----------	16 SOCIAL SECURITY NO: NONE	17 INFORMANT Address: Melvin Turner, Gambrills, Maryland	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute tracheobronchitis and bronchiolitis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) _____ DUE TO

(c) _____

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22. DATE SIGNED: July 27, 1967

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE THEREOF: 29 July 67	23c NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Pk.	23a LOCATION (City or Town) (County) (State): Glen Burnie, Maryland	
24 FUNERAL DIRECTOR: R.V. Singleton — ADDRESS: Singleton Funeral Home/Glen Burnie, Md.		25a RECD BY REGISTRAR DATE: JUL 31 1967	25b REGISTRAR'S SIGNATURE: Charles Judge	

M. TURNER

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21 Film 0391 6/15/67 eac

09099

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Severna Park~~ ANNAPOLIS
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A-A. Co. Gen. Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: A. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: Rt. 2 Box 628
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: KATHYLEEN — Last: UNDERWOOD
4. DATE OF DEATH: Month: July — Day: 8 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-13-47
9. AGE (In years last birthday): 20 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): College Student
10b. KIND OF BUSINESS OR INDUSTRY: Student
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John D. Underwood
14. MOTHER'S MAIDEN NAME: Mary Rose Madden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: John D. Underwood — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound in the chest — INTERVAL BETWEEN ONSET AND DEATH
719.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Shot in chest from over 12" range with .25 Caliber pistol
20c. TIME OF INJURY Month, Day, Year: Hour 8:15 p.m. July 7 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm factory, street, office bldg etc.): Home
20f. (City or town) Severna Park, (County) Anne Arundel, (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: [signature] M.D
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MED. EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county): July 8, 1967
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/10/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.
23d. LOCATION (City or Town) Landsdown (County) Anne Arundel (State) Md.
24. FUNERAL DIRECTOR: Edward L. Sarnacki
ADDRESS: Severna Park, Md.
25a. RECD BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

647 Hyac

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

29093 — 09-99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 306 DEWEY DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	M.	VALLILLO	JULY	26	19 67

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
MALE	CAUC.		18 APR 1917	50 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
engineer - electrical	US Gov't	Elizabeth, New Jersey	USA

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael Vallillo	Asunda Figuola

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT Address
yes WWII	144-015-235	LILLIAN S. VALLILLO, 306 DEWEY DR., ANNA., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION WITH CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____, 19__, and that death occurred at 11:57 M, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED
[signature]					

22c. PHYSICIAN'S NAME (Type)	22d ADDRESS
ARTHUR C. J. BRICKEL LT MC USNR	USNH, ANNAPOLIS, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	July 29, 1967	St. Mary's Cemetery	Annapolis A.A. Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOPPING FUNERAL HOME	WEST ST., ANNA., MD.	JUL 31 1967	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09100 — 09101

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 106 Market St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: — Last: VIGILANTE

4. DATE OF DEATH: Month: July — Day: 24 — Year: 19 67

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 8. DATE OF BIRTH: Sept. 4, 1914 — 9. AGE (In years last birthday): 52 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE — 10b. KIND OF BUSINESS OR INDUSTRY: HOME — 11. BIRTHPLACE (County & State, or foreign country): Annapolis Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William McCRONE — 14. MOTHER'S MAIDEN NAME: ElizABETH WARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): — 16. SOCIAL SECURITY NO: — 17. INFORMANT: Hospital RECORDS — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Metastatic CARCINOMA OF BREAST — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY. Month, Day, Year, Hour a.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (~~this person~~) attended the deceased from July 17, 19 67, to July 24, 19 67 that (I) (~~we~~) last saw the deceased alive on July 24, 19 67, and that death occurred at 5:45 PM, from causes and on the date stated above.

22a. SIGNATURE: R. Brenn — M.D. ATTENDING PHYS. XX MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 7/25/67

22c. PHYSICIAN'S NAME (Type): — 22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 7-28-67 — 23c. NAME OF CEMETERY OR CREMATORY: St. Hunes — 23d. LOCATION (City or Town) (County) (State): Annapolis MD.

24. FUNERAL DIRECTOR: John M. Ly Funeral Home — ADDRESS: Annapolis, Md. — 25a. REC'D BY REGISTRAR DATE: JUL 31 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09101 Item #9 Film #G [illegible] 09102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: A A Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: Md
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. Gen Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena Md
d. STREET ADDRESS: 213 Catalpa Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WADE Middle Gilbert Last Melvin

4. DATE OF DEATH: Month 7 Day 23 Year 67 · 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-26 08

9. AGE (In years last birthday): 58 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Arundel Corp

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wade

14. MOTHER'S MAIDEN NAME: Florence Beagle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217 01 4[illegible]

17. INFORMANT: Helen L. Vermillion — Address: Glen Burnie Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): A.E.V.D. & Possible Stroke
DUE TO (c): Senility

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

4221

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1965, 19__, to 1967, 19__, that (I) (we) last saw the deceased alive on 7-22-67 19__, and that death occurred at 7:1 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Hahn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-23-67

22c. PHYSICIAN'S NAME (Type): Robert R. HAHN

22d. ADDRESS: Severna Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-26-67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City, town or county) (State): Glen Burnie Md

24. FUNERAL DIRECTOR: Robert S. Barranco

ADDRESS: Severna Park Md

25a. REC'D BY REGISTRAR DATE: JUL 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

ROBERT S. BARRANCO

VR A15 (4)
20M 1/65

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09102 09103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY AA. Co. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) O.O.A - North Arundel Hosp

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a STATE MD b COUNTY AA Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
d STREET ADDRESS 401 - Ivan Hill Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First: LAWSON Middle: [illegible] Last: WARE

4 DATE OF DEATH Month: 7 Day: 9 Year: 19 67

5 SEX M

6 COLOR OR RACE N

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH 12-24-89

9 AGE (In years last birthday) 77 yrs

IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) VA

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Robert Ware

14 MOTHER'S MAIDEN NAME Josie Fortune

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No

16 SOCIAL SECURITY NO

17 INFORMANT Address: Eudora Ware Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory street office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. Linhardt M.D.

EXAMINER'S NAME (Type) E. Linhardt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED 7-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b DATE THEREOF 7-13-67

23c NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem

23d LOCATION (City or Town) Brooklyn (County) Md. (State)

24 FUNERAL DIRECTOR Emory O. Wilson ADDRESS 1000 Brantley Ave.

25a REC'D BY REGISTRAR DATE JUL 12 1967

25b REGISTRAR'S SIGNATURE J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09103 09104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
1SM 9/59

1 PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Box 506 Pasadena Rd — c. LENGTH OF STAY IN 1b: 6 mos

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Box 506 Pasadena Rd, Pasadena P.O.

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Same

d. STREET ADDRESS: Same

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: (NMI) — Last: Weishaar

4. DATE OF DEATH: Month: 7 — Day: 31 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/20/05

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months — Days —

IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Weishaar

14. MOTHER'S MAIDEN NAME: Christina Weisker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): 1944-1945

16. SOCIAL SECURITY NO: 216-05-1840

17. INFORMANT: Paul H. Weishaar — Address: Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO (b): Myocardial Infarction, Multiple — 3 yr.

DUE TO (c): Generalized Arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): —

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) (County) (State): —

21. I certify that (I) (this hospital) attended the deceased from 10/4 1949 to 7/27 1967, that (I) (we) last saw the deceased alive on 7/29 1967 and that death occurred at 1:10 P.M. from the causes and on the date stated above.

22c. SIGNATURE: G.W. Prichard — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22a. PHYSICIAN'S NAME (Type): G.W. PRICHARD MD

22d. ADDRESS: Glen Burnie, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3 Aug. 67

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

23d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Kirkley Funeral Home, Glen Burnie, Md.

25a. RECD BY REGISTRAR DATE: AUG 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

1

09104

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09105

1. **PLACE OF DEATH** a COUNTY: A.A. Co. — MARYLAND
   b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c LENGTH OF STAY IN 1b:
   d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 134 Homeland Ave.

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission) a STATE: M.D. b COUNTY: A.A. Co.
   c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d STREET ADDRESS: 134 Homeland Ave.
   e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William Middle: James Last: Wiedefeld Sr.

4. **DATE OF DEATH**: Month: 7 Day: 15 Year: 19 67

5. **SEX**: M

6. **COLOR OR RACE**: W

7. **MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. **DATE OF BIRTH**: 1-25-1896

9. **AGE** (In years last birthday): 71 yrs
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Boat Bigger

10b. **KIND OF BUSINESS OR INDUSTRY**: Bigger

11. **BIRTHPLACE** (County & State or foreign country): Balto. M.D.

12. **CITIZEN OF WHAT COUNTRY?**: U.S.

13. **FATHER'S NAME**: James M. Wiedefeld

14. **MOTHER'S MAIDEN NAME**: Annie Geis

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I

16. **SOCIAL SECURITY NO**:

17. **INFORMANT**: Wm J. Wiedefeld Jr. Address: #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): D.O.A. probably due to
DUE TO (b): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intermittent Claudication

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

20a. ACCIDENT WAS UNDER-LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19—

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-16, 19 67, to 7-15 19 67 that (I) (we) last saw the deceased alive on 6-4- 19 67, and that death occurred at 10:35 A.M. from causes and on the date stated above.

22a. SIGNATURE: Paul M Shipley — ATTENDING PHYS. M.D. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-17-67

22c. PHYSICIAN'S NAME (Type): For the Med

22d. ADDRESS: Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-17-67

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City or Town) (County) (State): Annapolis MD.

24. FUNERAL DIRECTOR: John M. Ely Son & Hum ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Juegen

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09105

CERTIFICATE OF DEATH

09106

1 PLACE OF DEATH
a COUNTY: A. A. — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b COUNTY: A.A.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Rt. 9 Box 202
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: (Joe) — Last: Wilkes

4. DATE OF DEATH: Month: July — Day: 1 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12, 1894

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired laborer

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): S. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES WILKES

14. MOTHER'S MAIDEN NAME: JANE WILKES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 213-03-7401A

17 INFORMANT: Mrs. Mary Wilkes — Address: Pasedena, Md. Route 9 Box 202

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Septicemea
DUE TO (b): Adenocarcinoma prostate
DUE TO (c): Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-7-67

23c. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cem.

23d. LOCATION (City or Town) (County) (State): A.A. CO., Maryland

24 FUNERAL DIRECTOR: MORTON & DYETT F.H. — ADDRESS: 1701 Laurens St.

25a. REC'D BY REGISTRAR DATE: JUL 7 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09106

09107

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Arnold~~ Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Arnold
d. STREET ADDRESS: Box 394
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Hampton — Middle: Mitchell — Last: WILLEN

4 DATE OF DEATH: Month: JULY — Day: 7 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: August 20, 1897

9 AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Staff Accountant Ret.

10b KIND OF BUSINESS OR INDUSTRY: C & P Tel. Co.

11 BIRTHPLACE (County & State, or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Dandridge J. Willen

14 MOTHER'S MAIDEN NAME: Etta Emma Rock

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 212-10-0808 A

17 INFORMANT: Mr. Robert H. Willen — Address: 109 2dnd Ave. Brooklyn Park 21225

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ventricular fibrillations, secondary to
DUE TO (b): Antriolateral Myocardial dysfunction 19d
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): old Anterior myocardial infarction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-10-, 1967, to 7-7-, 1967, that (I) (we) last saw the deceased alive on 7-7- 1967, and that death occurred at M, from causes and on the date stated above

22a SIGNATURE: Frank M Shipley M.D. — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b DATE SIGNED: 7-8-67

22c. PHYSICIAN'S NAME (Type): Frank M. Shipley, MD.

22d ADDRESS: 121 Cathedral St. Annapolis Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 11, 1967

23c NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery

23d LOCATION (City or Town) (County) (State): Pikesville, Md. Balto. Co.

24. FUNERAL DIRECTOR: McCully Funeral Home — ADDRESS: 237 Patapsco Ave. Baltimore, Md.

25a RECD BY REGISTRAR DATE: JUL 11 1967

25b REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09107 09108

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.A.C.H.A. General Hosp.

2. USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: W. — Last: Wilson

4. DATE OF DEATH: Month: 7 — Day: 11 — Year: 1967

5. SEX: female

6. COLOR OR RACE: Col.

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 11-1-1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Diggs

14. MOTHER'S MAIDEN NAME: Mary E. Diggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Carr — Address: Severna Park, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Congestive Heart Failure
DUE TO (b): Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19:

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sept 13, 1954

20f. (City or town) (County) (State):

21. I certify that (I) (this hospital) attended the deceased from ~~July~~ 1, 19~~47~~ to 7/11, 1967 that (I) (we) last saw the deceased alive on 7-11 1962, and that death occurred at ~~2~~ M, from causes and on the date stated above.

22a. SIGNATURE: Faye W. Alter — M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-11-67

22c. PHYSICIAN'S NAME (Type): Faye W. Alter

22d. ADDRESS: 62 Cathedral St Ann

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/15/67

23c. NAME OF CEMETERY OR CREMATORY: John Wesley

23d. LOCATION (City or Town) (County) (State): Waterbury A.A. Md.

24. FUNERAL DIRECTOR: William Reese, II

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09108 **CERTIFICATE OF DEATH** 09109

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Glen Burnie P.O.
c. LENGTH OF STAY IN this MARYLAND: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rte.1, Box 271-A, Solley Road

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Glen Burnie P.O.
d. STREET ADDRESS: Rte.1, Box 271-A, Solley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THERESA (Walinski) Last WOLINSKI

4. DATE OF DEATH: Month July Day 28, Year 1967.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 4, 1898

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Anuszewski

14. MOTHER'S MAIDEN NAME: Maryanna Grozinski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: None

Address: Mr. Andrew Wolinski, Rte.1, Box 271-A, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Severe Arteriosclerotic Cardiovascular Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diffuse Encephalopathy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify ~~that~~ (I) (~~this hospital~~) attended the deceased from Feb. 1, 1966, to July, 1967, ~~that (I)~~ (we) last saw the deceased alive on 7/19, 1967, and that death occured at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Mario J. Reda M.D.

22b. DATE SIGNED: 7/29/67

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): MARIO J. REDA M.D.

22d. ADDRESS: 4016 RITCHIE HWY BALTO. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/1/67

23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: M.F. SADOWSKI & SONS, 1808 EASTERN AVE

25a. REC'D BY REGISTRAR DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event (within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

99103

CERTIFICATE OF DEATH

10531

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Maryland
d. STREET ADDRESS: [illegible] Crownsville, Maryland 21032
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John		Wormley	7/25		1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
M	N		1878	89 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	unknown	unknown	unknown

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	unknown	Hospital Records, Crownsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Adeno Carcinoma of stomach with extensive mel-
DUE TO: astasis to liver and lymph nodes.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old pulmonary T.B.; Chronic Brain Syndrome

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/4, 1943, to 7/25/, 1967, that (I) (we) last saw the deceased alive on 7/25, 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☒	22b. DATE SIGNED
[signature]					7/27/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
L. Mapp, M.D.	Crownsville State Hospital, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF.	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	8-9-67	U. of Md. Med. School	Baltimore Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm. Reece Mortuary 108 W. Washington St. Hagerstown	AUG 11 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09110

CERTIFICATE OF DEATH

09119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN 1b: 6 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): North Arundel Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum
   d. STREET ADDRESS: 440 Shipley Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: S. — Last: Wroten

4. **DATE OF DEATH**: Month: 7 — Day: 9 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-93

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: General Work

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Edward Wroten

14. MOTHER'S MAIDEN NAME: Mary Lusby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-16-2240

17. **INFORMANT**: Address: Charts by Mrs Iona Restivo - Linthicum Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
   DUE TO (b): Cerebro Vascular Disease — 5 years
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   332 X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Left Lower Lobe Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-6-, 1967, to 7-9, 1967, that (I) (we) last saw the deceased alive on 7-8- 1967, and that death occurred at 6:50 AM, from causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 7-9-67

22c. PHYSICIAN'S NAME (Type): H.T. O'Herlihy

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: Solomons Methodist Cem

23d. LOCATION (City or Town) (County) (State): Solomons Calvert Md.

24. FUNERAL DIRECTOR — ADDRESS: A.A. Harkins & Son, Port Republic Md

25a. REC'D BY REGISTRAR — DATE: JUL 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Snyder

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Galesville

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Louis — Middle: — Last: Zang

4. **DATE OF DEATH**: Month: July — Day: 29 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-8-92

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): A. A. Co. - Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: William Joseph Zang

14. MOTHER'S MAIDEN NAME: Amelia Matilda Siegert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-28-3278

17. **INFORMANT**: Eldridge Zang — Address: Davidsonville, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(b): Arteriosclerotic heart disease — several months
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 20, 1967, to July 29, 1967, that (I) (we) last saw the deceased alive on July 29, 19 67, and that death occurred at 2 PM, from causes and on the date stated above.

22a. SIGNATURE: Willard F. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/11/67

22c. PHYSICIAN'S NAME (Type): Willard F. Smith MD

22d. ADDRESS: Shady Side, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-1-67

23c. NAME OF CEMETERY OR CREMATORY: Quaker

23d. LOCATION (City or Town) (County) (State): Galesville - A.A. Co. Md.

24. FUNERAL DIRECTOR: Bernard O. Hardesty — ADDRESS: Galesville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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